



A Message from the President

Dear Colleagues,

Humidity aside, I am hoping that all of you are enjoying the season! With Musikfest and the Eagles training camp behind us... the Phillies are trying to hold onto that first-place slot, and the Iron Pigs are showing signs of improvement as we prepare for stretch runs into the Fall.

Over the past few months, EPAHEN has continued to stay very busy. On June 5, we were back at the Brookside Country Club for Brian Eury's (Hospital & Health Association of Pennsylvania) "Legislative Update." Approximately 50 people attended this event focusing on the healthcare challenges looming in the future. Once again, I want to thank our long-lasting sponsor, HCSC, for their continuous support over the past years.

Then on July 17, we had our annual summer social at Coca-Cola park. Over forty people attended our event this year in watching our Iron Pigs take on the Scranton-Wilkes Barre Yankees. While the weather initially presented challenges, everyone had a great time in this beautiful new facility. As we move towards the Fall and Winter, we do have some events being finalized. We are projecting at least one event in September/October, and our annual event at DeSales University in late November/early December. Please continue to check the website and your email for more information.

With the focus shifting to the Fall, I want to remind all of you of a few key subjects. First, we are getting close to finalizing the names for the upcoming election and subsequent new Board. While our President-Elect Steve Kaja has been tirelessly recruiting, there is still time to consider a leadership position, or committee membership. Secondly, upcoming ACHE clusters are coming to our area. In September, a two day cluster will take place in Baltimore, and in October, another two day cluster will take place in Philadelphia. As you are aware, these clusters offer valuable Category I credits in your efforts to either become FACHE credentialed, or re-certify if you are already a Fellow. Finally, I want to encourage all of you to reach out to colleagues and friends in joining ACHE, and our chapter. Our growth and diversity are truly one of our greatest strengths now, and moving into the future.

Regards,
Andrew B. Starr, FACHE
President-EPAHEN

Calendar of Events

Eastern Pennsylvania Healthcare Executive Network (EPAHEN)

October 2, 2008 * 6:00pm

EPAHEN Membership Meeting

Good Shepherd Rehab Hospital

Speaker: Dr. Barbara Connors, Centers
for Medicare & Medicaid Services

Program: Responding to 'Never Events'
and Value-Based Purchasing

Healthcare Leadership Network of the Delaware Valley (HLNDV)

September 18, 2008

Program: Senior Leader Perspectives on
Healthcare in 2020

October 15, 2008

Program: Career Development 4X4:

"Practical Workplace Tips for the Early
Careerist" (What they don't teach you in
Grad School!)

American College of Healthcare Executives (ACHE)

September 8-11, 2008

San Francisco, CA Cluster

September 15-18, 2008

Baltimore, MD Cluster

October 20-23, 2008

Philadelphia, PA Cluster

November 17-18, 2008

Scottsdale, AZ Cluster

*Information on these, and other upcoming
local, regional and national events*

is also available at the EPAHEN web site:

<http://epahen.ache.org>

(note: no "www" !)

Notes From ACHE

Building Blocks for Reform. *Health Affairs (Quarter 2, 2008) Schoen, Cathy; Davis, Karen; Collins, Sara R.* According to a recent Commonwealth Fund study, a pragmatic solution to the current health insurance crisis would combine the best of private-market coverage and publicly sponsored insurance. While employer-sponsored health plans pool risk among a large group of people to ease sign-up and enrollment for consumers, Medicare provides lower administrative overhead. The Building Blocks framework's guiding principles include offering accessibility and affordable, minimum coverage to all U.S. residents, providing residents with a choice of physicians and health plans, lowering administrative costs, increasing shared responsibility for healthcare costs and pooling health risks more broadly. The framework will require the establishment of an insurance connector or a program mirroring Medicare for those under age 65. Additionally, employers either would be required to offer employees health insurance or pay a 7 percent payroll tax, which would be used to fund the public program and provide workers who frequently change jobs with a stable insurance option. Other public healthcare programs would be maintained and expanded under the framework. All residents would be required to have healthcare insurance and verify coverage through annual tax filings. A Lewin simulation estimated that the number of uninsured people would fall to 3.6 million in the first year of implementation from 48.3 million in 2008. Total health spending would rise less than 1 percent in the first year, with most of the spending increases offset by lower administrative costs and provider reimbursements.

The Billion Dollar U-Turn. *Hospital & Health Networks (May 2008) Taylor, Mark.* Medicare spent more than \$15 billion on hospital readmissions of Medicare patients, according to a June 2007 Medicare Payment Advisory Commission report. About 17.6 percent of Medicare patients who were discharged from hospitals were readmitted within 30 days in 2005. Experts indicate up to 75 percent of these readmissions could have been prevented, which highlights the costly nature and poor integration of the current healthcare system. Some healthcare officials and critics urge hospitals to disclose their readmission rates as a way to inform patients and foster improvements; but hospitals contend that when patients are discharged, they sometimes enter other facilities, like nursing homes, leading to readmissions if care is not properly rendered. To curb readmissions, the Fuqua Heart Center at Atlanta's Piedmont Hospital launched a telehealth program that monitors patient health status. This has reduced 30-day readmission rates for heart attack patients by 75 percent. Meanwhile, using The Joint Commission quality measures, Intermountain HealthCare in Utah reduced heart failure readmissions by 40 percent. Hospitals will continue to feel intense pressure from regulators, patients and insurers to reduce readmission rates, with the U.S. Centers for Medicare and Medicaid Services looking to limit or deny payments for preventable readmissions. Hospitals, however, have very few incentives to curb readmissions because they do not have the funds to invest in the technology or staff necessary to reduce them, though some have indicated that the use of clinics to reduce complications and tackle wound care patients has helped.

A Healthy Future for Healthcare Building. *Medical Construction & Design (May 2008) Lawson, Scott H.* According to the California Environmental Protection Agency, green facilities are those that protect occupants, improve productivity, efficiently utilize resources and reduce environmental impacts. Green building is catching on in the healthcare sector because it encourages staff to maintain healthy behaviors and boost profits, say experts. A 2000 study by William J. Fisk of the Lawrence Berkeley National Laboratory estimated that the four most common respiratory illness caused 176 million days of lost work at a cost of \$70 billion annually, inclusive of treatment costs. By improving indoor air quality rules and standards, Fisk forecast that companies could save \$160 billion overall. A healthier workplace features such improvements as increased ventilation, less air recirculation, better filtration, ultraviolet disinfection of air, reduced office sharing and reduced density of occupants. A 2007 survey by Turner Construction Company, the U.S. Green Building Council and McGraw-Hill Construction reports 47 percent of hospital administrators find that patient recovery times fall when green construction practices are used. Investing in methods for purifying air can reduce infection rates, according to experts. Beyond patient care improvement, green buildings ultimately reduce energy consumption by up to 30 percent on average, according to the U.S. Department of Energy, and "green" hospitals often find staff recruitment less burdensome. Only about 20 Leadership in Energy and Environmental Design (LEED) projects are healthcare related because initial investments in green construction can be hefty. However, over the long-term, the return on the investment is increased productivity from happier workers, lower infection rates, higher patient satisfaction, lower energy costs and improvements in patient care.

The Wisdom and Justice of Not Paying for 'Preventable Complications.' *Journal of the American Medical Association (May 2008) Pronovost, Peter J.; Goeschel, Christine A.; Wachter, Robert M.* Pay-for-performance programs are cropping up throughout the healthcare market, and the U.S. Centers for Medicare and Medicaid is leading a new initiative to stop payments for eight preventable complications beginning in October 2008. These complications include foreign items retained in patients after surgery, urinary tract infections, central line-associated bloodstream infections, patient falls and pressure ulcers. Several other complications such as ventilator-associated pneumonia are under consideration for 2009. However, there could be more false positives than accurate positives, which could contribute to lower quality care and higher costs. Experts caution that without a standard program to monitor these errors, pay-for-performance programs could become biased. Critics are concerned that the biases will lead hospitals to turn away the sickest patients because they are no longer receiving payments for those patients due to allegedly preventable complications. If hospitals cannot charge for a complication they cannot prevent, trust in quality improvement programs may be lost, the occurrence of diagnosis after admission may decline, and the community may not receive accurate information. An effectiveness study with vigorous measurement from a wide range of healthcare organizations can help determine whether a complication is preventable, say experts. Systems also will want to monitor whether complication rates vary between facilities and whether they correlate with the quality care. Before complications are placed in the "not paid for preventable complications" category they should be identified as important, measurable and greatly preventable, say observers.

A Different Voice: Nurses on the Board. *Trustee (June 2008) Meyers, Susan.* Several surveys in 2007 and 2008, including one conducted by the Robert Wood Johnson Foundation (RWJF), reveal that very few hospital boards include nurses. Some say the traditional role of nurses as care

implementers has prevented them from entering the boardroom as healthcare decision makers. However, as more and more nurses hold more than one college degree and leadership positions within the hospital and community, their presence could be necessary to boardroom dynamics. RWJF's "Nurse Leaders in the Boardroom" campaign hopes to foster connections between nurses and healthcare organizations because nurses are at the center of patient care and directly impact quality and safety. Quality care and patient safety are areas where nurses have the most expertise, which can help boards make appropriate decisions, says RWJF Senior Program Officer Susan Hassmiller. A recent Nursing Economics study reveals that chief nursing officers are more attune to Institute of Medicine patient safety reports than hospital executives. "Many nurse leaders also have good financial backgrounds [and] strategic thinking and can bring a lot of high-level skill sets to the governance of hospitals," says Pamela Thompson, CEO, American Organization of Nurse Executives. Experts add that including nurses in board decisions is only a natural progression, given that nurses can demonstrate evidence-based safety and quality improvements through their in-depth knowledge of the patient care process. As the Centers for Medicare and Medicaid Services decides whether full payment is contingent upon hospitals disclosing patient satisfaction data, boards will need nurse input to determine how best to capture that data.

Hospitals Move to Reduce Risk of Night Shift. *Wall Street Journal (May 28, 2008) Landro, Laura.* Recent studies indicate that more medical errors, complications and deaths occur in hospitals at night when they are not fully staffed. Of the 62,814 heart attack patients involved in a study published in April in the journal *Circulation*, more than 50 percent were treated at night, and their chances of receiving an angioplasty within the recommended 90 minutes was 66 percent less likely than patients receiving care during the day. In response, hospitals increasingly are hiring nocturnists to handle the night shifts; the Society of Hospital Medicine reports a jump in the number of hospitals with nocturnists or hospitalists handling night hours to 1,200 in 2007 from 700 in 2003. Other hospitals have intensive-care doctors working at night, requiring that they handle emergencies that pop up throughout the facility. Additionally, hospitals are beefing up communication when shifts change and taking steps to reduce night nurses' workloads. Dr. David Longnecker of the Association of American Medical Colleges notes that night nurses overwhelmed by the number of patients under their care are more likely to take shortcuts that could create patient safety issues, such as changing IV bags without making sure the name on the patient's wristband matches the name on the medication.

Health Insurance Falling Short for More People. *Wall Street Journal (June 13, 2008) Gerencher, Kristen.* According to a recent Commonwealth Fund report, the number of underinsured working adults in American rose 60 percent in 2007 to more than 25 million. The current economic climate and the rise in medical costs could leave these workers without sufficient coverage should a major procedure or medical treatment become necessary. The rate of underinsurance among wealthier families, those earning \$40,000 or more, rose threefold, according to the report. Commonwealth Fund President Karen Davis says, "Lack of insurance is only one part of the problem, as even the insured have serious gaps in coverage. Insurance coverage is the ticket into the healthcare system, but for too many that ticket doesn't buy financial security or genuine access to care." Households spending 10 percent or more of their income on healthcare costs, or 5 percent of their income if they are low-income households were considered underinsured for the study, which was published online by Health Affairs. While health insurance premiums for family coverage increased nearly 80 percent since 2001, wages only rose 19 percent and inflation rose 17 percent, according to Kaiser Family Foundation. In 2007, more than 40 percent of adults were considered underinsured, up from 33 percent in 2003. The Commonwealth Fund believes the healthcare and insurance sectors must move in a different direction if they hope to provide patients with the quality care they need given that 53 percent of the underinsured, 68 percent of the uninsured and 31 percent of the adequately insured forgo needed care because of its cost.

Can Even High-Ranked Hospitals Get Better? *Wall Street Journal (June 10, 2008) Winslow, Ron.* A study published in the June 10 issue of *Circulation*, journal of the American Heart Association, indicates that hospitals with high scores for coronary-bypass outcomes on hospital report cards could do more to improve care quality and mortality rates. Of 40,000 bypass operations handled at nine hospitals in Ontario from 1998 to 2003, there were only 347 deaths; of these, 111 were deemed preventable. The study points to such things as lapses in procedures, the need for better coordination among surgical teams, the inability to identify infections early on and the absence of certain medical devices and determines that hospitals and consumers should not rely on hospital report cards alone. Dr. Chris Feindel of Toronto-based University Health Network, a co-author of the study, notes, "It ends up being one preventable death per surgeon every two years. The numbers are very small, but they're still preventable deaths." He states that lower-risk patients made up a large number of the preventable deaths.

Patient Feedback More Important Than Ever to Hospitals. *Pantagraph (June 15, 2008) Swiech, Paul.* The latest trend in hospital patient care is to encourage patients and their relatives to express concerns, compliments or suggestions to medical staff before the patient is discharged or complications arise. Many hospitals have polled patients for some time, but more are publicly disclosing survey results as part of the federal Hospital Compare Web site. This Web site allows patients and their families to evaluate healthcare facilities based on the level of communication between staff and patients and whether patients would recommend the hospital to friends and relatives. Because treatment is administered more quickly, communication is critical for medical professionals to know whether the treatment is working or not. Mark Dabbs with OSF St. Joseph Medical Center in Bloomington, Ill., reports that patients need to speak up and ask questions so that they can get a realistic idea of what to expect in terms of treatment. Dabbs and Clinical Director Stephanie Moore with the BroMenn Regional Medical Center advise each patient to designate a family representative that staff can talk to if the patient is unable to receive information. Establishing good communication between patients and staff early on can reduce patient anxiety about raising concerns or asking questions about treatment. Experts recommend hospitalized patients ask questions about their condition, the recommended procedure, possible side effects and the duration of recovery. Other questions should touch upon pain management, length of hospitalization and when solid foods can be eaten.

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