September 2011

Facts & Features

AHA Services, Inc.
A for-profit subsidiary of the Arkansas Hospital Association

Fall

Volume 16, Issue 4

Developing and providing value-added services and programs, which benefit the members of the Arkansas Hospital Association

AHA SERVICES ENDORSES nTELAGENT

AHA Services, Inc. (AHASI), a subsidiary of the Arkansas Hospital Association (AHA), announces **nTelagent** as an endorsed provider of financial and reimbursement services.

"Part of our mission at AHASI is to identify best-in-class solutions for our member hospitals," says Tina Creel, vice president of AHASI. "For those facilities seeking to streamline point-of-service processes and adjust to today's payment landscape, **nTelagent** offers a proven solution."

nTelagent's services allow participating members of the AHA to leverage the company's total point-of-service package to increase collections, decrease bad debt and better communicate with their patients regarding financial matters on the front end.

Similar to applications used in the retail industry at the point of sale, **nTelagent's** web-based, automated Retail Application for Healthcare guides patient access staff through each patient encounter via real-time, customized scripts.

In minutes, registrars using **nTelagent** validate the patient's address, verify insurance, determine estimated total and approved charges and follow online scripts for discounts, payment terms and patient collections – all at point of service and within a single, integrated system.

Continuing to meet its clients' needs to maximize the bottom line in a difficult and ever-challenging market, **nTelagent** plans the addition of medical necessity screening as an option module beginning in the fourth quarter of 2011.

nTelagent allows hospitals to settle all patient accounts – insured, uninsured and those qualifying for financial assistance – on the front end.

Hospitals using **nTelagent** increase cash, upfront and overall; decrease bad debt and AR days; reduce denials, returned mail and collection fees; identify capacity to pay and financial assistance; set up payment terms for increased ongoing collections; and improve registrar workflow and patient satisfaction.

"We're honored to be an AHASI-endorsed vendor, and look forward to working with Arkansas hospitals," says Earl Winter, nTelagent CEO. "The **nTelagent** system can dramatically improve a facility's bottom line, allowing hospitals and other providers to focus on what matters most – providing high-quality care and service to their communities."

About nTelagent, Inc.
nTelagent's total point-of-service solution, the Retail Application for Healthcare, guides patient access staff through each patient encounter via real-time, customized scripts. From insurance verification to payment processing, registration is fast, simple and accurate for all patients: insured, uninsured and those qualifying for financial assistance. **nTelagent's** clients increase upfront cash and cash on hand, reduce AR days and bad debt, reduce or eliminate back-end denials, and follow consistent practices on all registrations with just one system – for a fraction of the cost as compared to dis-parate systems.

Visit www.ntelagent.com or contact Jaclyn O'Neil, 225.933.7013.

What's inside:

Face-off: Social Media Site vs. Corporate Website

Should Brands Refer to their Social Media Sites or Corporate Website?

More and more healthcare organizations are now using Facebook or Twitter to advertise and create brand awareness. Does this mean it's the end of an era of cleverly designed and graphically tantalizing corporate websites? Should major healthcare companies focus on using social media machines to recruit talent instead? We talk to a few experts to find out.

What's the Fascination with Social Media?

What's the fascination with social media and why are so many corporations quickly finding themselves on social networking sites? It's true that most of them still operate a dedicated website, but is it possible that this might one day become just a legacy?

Michael Marlatt, recruiting consultant at Microsoft, and founder of mRecruitingcamp, North America's first ever mobile recruiting conference, currently handles social media for Microsoft MCSC consulting services. He says there are several reasons companies are gravitating to social media sites such as Facebook and Twitter to promote their corporate brand.

Number one, he says it's because social networks already have a community and people are going there for specific reasons: to engage with their friends, family, potential colleagues and people they don't know. “The point is, they're already there,” Marlatt says “don't try to re-create the wheel when the wheel is already created for you.”

The recruitment expert says every company is trying to develop its own talent community where they're trying to pull potential customers and employees to their own company site, but ultimately these communities already exist on social networking sites. There have been companies that have tried to replicate communities on their own corporate website, but they have not been as successful.

You would be hard-pressed to find a big company that doesn't have a social media presence now. The main reason behind this is that companies want to integrate and to go where their audience is. From a job seeker’s point of view, going to a company's Facebook profile, for example, is an easy and non-threatening way to be interested in a company and find out more about it, including career opportunities.

In order to form the best strategy, however, Marlatt says companies need to consider who their primary audience is. If your audience is leveraging text messaging, augmented reality QR, visual recognition, proximity-based marketing apps or gaming apps, you should adjust your corporate marketing and recruiting strategy to engage the audience where it is most likely to be.

Once a strategy is established, the business can determine where it should be focusing its marketing and recruiting efforts. According to social media strategist Sally Falkow, websites without social features and no connection to the brand's social presence are becoming irrelevant.

At the same time, Falkow writes in her article that while Facebook, Twitter and YouTube are essential tools in a company's online strategy, they need to be simultaneously connected to a very robust and informational website.

David Tuttle, director of digital strategy at TMP Worldwide, one of the largest advertisement recruitment agencies worldwide, agrees and says recruiters for corporations need to keep in mind that social networking is only one tool for successful recruiting.

"Social networking is extremely important, don't get me wrong," Tuttle says, "but it's not the only method for successful recruiting." The digital strategist says an agency like TMP provides a comprehensive method for recruiters and HR departments to advertise open positions. The digital strategist says implementing a social networking experience is what's called using "targeted passive media" because it's a passive way to attract candidates. He says this strategy should be coupled with "targeted active media," which are useful tools such as job boards and job search aggregators to ensure that the best and the brightest candidates find and apply to open positions. Tuttle and Marlatt agree that job boards still play a very important role in helping to further the brand by advertising and marketing companies that are looking to reach a broader audience.

This is because most people have grown up with the notion that when they are looking for a job, they don't want to just look at one company, they want to look at multiple companies from a job aggregator.

Whether or not social media is a fad, it has been heavily debated. Marlatt says it's hard to call a social networking site of 600 million a fad.

On the contrary, he says social networking sites are becoming just like Google, where they have become fully integrated in a lot of different ways: They are becoming a place where businesses can operate their store-fronts, develop ways to further their brand, advertise their company and career opportunities, and engage their communities.

Indeed, the consensus among the experts is that social media sites are far from being a fleeting fad; in fact, it's merely just the beginning.

About the Author

Suvarna Sheth researches and writes about job search strategy, career management, hiring trends and workplace issues for HEALTHeCAREERS.com.

Visit http://assoc.healthecareers.com/aha or contact Gary Seaberg, 214.256.4811.

Come visit the AHA Services, Inc. endorsed companies exhibiting at the AHA Annual Trade Show, Thursday, October 6

AHA Workers' Compensation Self-Insured Trust
- Booth 10

Amerinet
- Booth 36

BancorpSouth Insurance Services, Inc.
- Booth 5

***care*Learning / *care*Skills**
- Booth 12

Commerce Bank / ControlPay® Advanced
- Booth 35

DocuVoice
- Booth 21

Guldmann, Inc.
- Booth 22

Hagan-Newkirk Financial Services
- Booth 18

HEALTHeCAREERS
- Booth 20

Information Solutions
- Booth 16

Medefis
- Booth 15

Med Travelers
- Booth 19

Merritt, Hawkins
- Booth 19

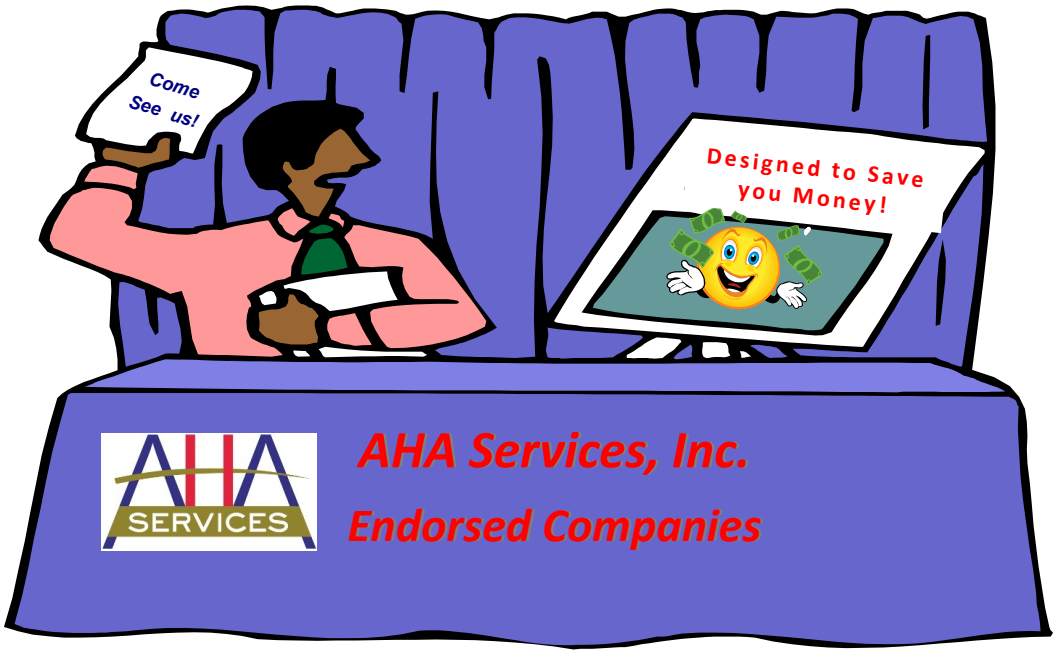
nTelagent
- Booth 17

Press Ganey
- Booth 13

Professional Data Services (PDS)
- Booth 34

Staff Care
- Booth 19

Vision Service Plan
- Booth 11



The Time to Prepare for Value-based Purchasing is Now

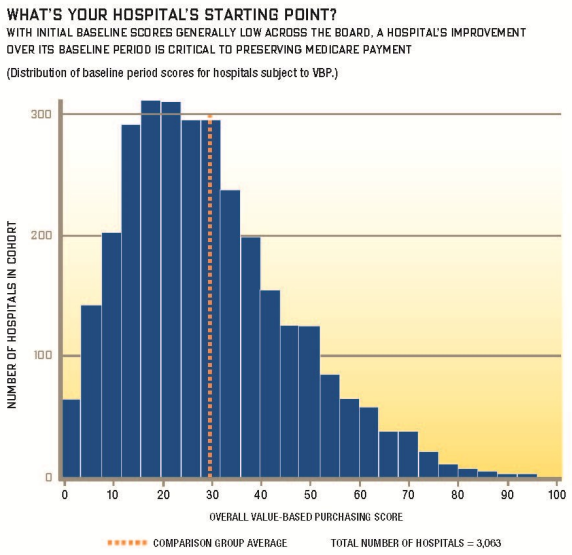
PRESS GANEY™
Outcomes driven. Performance strong.

Calculating Risk and Strategizing for Improvement as a New Payment Methodology Hits Home. By Nell Buhlman, Vice President of Clinical Products; and Nikolas Matthes, MD, PhD, MPH, vice President of Research and Development, Clinical Products, Press Ganey Associates.

Although value-based purchasing (VBP) has been on the collective radar screen of hospital quality improvement and patient satisfaction professionals for some time, the Patient Protection and Affordable Care Act of 2010 has elevated VBP awareness—and concern—to the executive suite and the board room.

The reason for the sudden interest isn't hard to fathom—under this new payment scheme, a portion of virtually every hospital's Medicare reimbursement is at risk, beginning with 1% in fiscal year 2013 and growing to 2% in 2017. Those percentages translate into serious money; on average, U.S. hospitals will have from $500,000 to $850,000 at risk annually under this program.

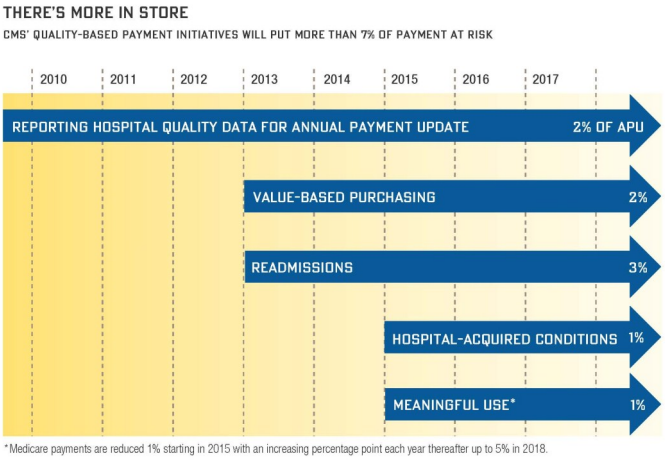
This concern has taken on new urgency in the wake of the Centers for Medicare and Medicaid Services' (CMS) release of the final rule for the Hospital Inpatient Value-based Purchasing Program. The final rule underscores the fact that only a small percentage of hospitals will retain full reimbursement (See chart below).



The concept of having Medicare revenue at risk is not new to hospitals. Since 2005, 2% of hospitals' Medicare Annual Payment Update has been linked to facilities' ability to successfully and accurately collect and submit data on a subset of the National Hospital Quality Measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures to CMS.

The measurement areas of interest for VBP are similar to those used for public reporting, but the stakes are considerably higher—2% of Medicare DRG payments to hospitals—and success more difficult to achieve, for under VBP, winning back some or all of the Medicare withhold will be tied to attaining specific performance thresholds or showing sufficient improvement on the measures, not just reporting the data.

Hospital leaders should not underestimate the magnitude of this shift from pay-for-reporting to pay-for-performance. As the chart below shows. CMS' plans for quality-based payment call for placing a much greater portion of hospitals' Medicare dollars at risk in the coming years.



Helping With the Higher Math of VBP

THE VBP regulations announced by CMS included some changes to prior models, notably one promulgated by CMS in 2007.

The regulations create a linear exchange function that will convert VBP scores into a percentage of the Medicare withhold a hospital will get back. A hospital with VBP scores at the median will be entitled to 50% of its withhold and a hospital at the 100th percentile will be entitled to 100% of its withhold. (Gone is an earlier proposal that would have established a 90th percentile benchmark to attain full reimbursement.) And yet, there is some uncertainty in this calculus; if a substantial number of hospitals are lower performing, then CMS will increase the slope of the exchange function to redistribute leftover incentive funds to high achievers. Extremely high performers may even receive more than the full withhold. The slope of the exchange function for redistributing incentive dollars won't be known until after the initial performance period when the first round of VBP scores will be calculated and it will be clear how much of the incentive pool remains.

This level of uncertainty in the calculus puts a premium on maximizing performance on all of the quality measures that make up the VBP program.

VBP Continued on Page 5

VBP Continued from Page 4

To help hospitals estimate how their payment could be affected by VBP, Press Ganey recently unveiled its Value-Based Purchasing Calculator (see graphic, below). Already in use at dozens of hospitals and health systems, providers have found the tool to be valuable. "The VBP tool has given us a tremendous resource to be able to track our performance and the performance of our physicians in complying with the government's pay-for-performance standards," says Jeff Fried, president and CEO of Beebe Medical Center in Lewes, Delaware "Without such a tool, I'm not sure how we would be able to both track our compliance and quantify our performance. By using this tool to share our collective results with the board and our medical staff, we have already seen a significant improvement in our overall performance." The tool has already been revised to reflect the new CMS proposal.

There's a reason the tool is so valuable, as we will see. As with other payment methodologies, things get complicated when you start digging.

For starters, each clinical measure and satisfaction domain can earn a maximum of 10 points. The VBP scoring methodology assesses hospitals on both achievement (where performance must reach or exceed a measure-specific threshold) and improvement (where performance is compared to the prior year's performance). The facility receives the higher of the two scores (improvement or achievement) for each measure. By awarding points in this manner, the model aims to ensure that poor-performing facilities are not doomed to a cycle of continued failure, but instead are incentivized to improve.

To assess achievement, a threshold and benchmark is set for each measure; if a hospital hits the threshold for that measure, it receives one VBP point. If the hospital performs at the benchmark, it receives 10 VBP points for that measure.

To assess improvement, the facility's performance during the baseline year is determined and VBP points are assigned for improvement from the baseline to the facility's performance in the assessment year for each measure. (For the first year of the program, however, CMS will use a nine-month baseline period July 1, 2009 through March 31, 2010. The performance period on which scores will be based will be July 1, 2011 to March 31, 2011.)

What's in the Measures

The National Hospital Quality Measures included in the clinical component of the program have been refined, reflecting the fact that a number of measures originally proposed are already "topped out," leaving little room for additional improvement (See list below).

CMS' Proposed Value-based Purchasing Measures

Clinical Measures	
AMI-7A	Fibrinolytic therapy received within 30 minutes of hospital arrival
AMI-8A	Primary PCI received within 90 minutes of hospital arrival
HF-1	Heart failure patients discharged with written instructions or educational materials
PN-3B	Blood culture performed in the ED prior to initial antibiotics
PN-6	Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients
SCIP-INF-1A	Prophylactic antibiotics received within one hour prior to surgical incision – overall rate
SCIP-INF-2	Prophylactic antibiotics for surgical patients selected
SCIP-INF-3A	Prophylactic antibiotics discontinued within 24 hours after surgery end time
SCIP-INF-4	Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
SCIP-CARD-2	Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period
SCIP-VTE-1	Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered
SCIP-VTE-2	Surgery patients who received appropriate VTE prophylaxis within 24 hours prior to surgery to 24 hours after surgery
Satisfaction Measures	
HCAHPS-1	Communication with nurses
HCAHPS-2	Communication with doctors
HCAHPS-3	Clean/quiet room
HCAHPS-4	Responsiveness of hospital staff
HCAHPS-5	New medicines explained
HCAHPS-6	Pain management
HCAHPS-7	Discharge information
HCAHPS-8	Overall hospital rating

The HCAHPS portion remains the same eight domains, weighted equally. In addition to earning points on achievement and improvement, hospitals can also earn up to 20 consistency points in the satisfaction domain. Consistency points measure how well hospitals are meeting achievement thresholds across the eight HCAHPS dimensions. To receive all 20 points, hospitals must be performing above the 50th percentile on all HCAHPS measures.

The points for the clinical measures are added to calculate a clinical score; the points for the satisfaction measures are added to calculate a satisfaction score.

VBP Continued on Page 6

VBP Continued from Page 5

The clinical and satisfaction scores combine with a 0/30% weighting, respectively, to establish the hospital's overall VBP score, also referred to as its Total Performance Score. That score is then used to calculate a percentage score representing VBP points earned out of total possible VBP points.

Where to Focus on Improving

Believe it or not, hidden in the calculus are some opportunities. Everyone in the hospital community is asking how their hospitals can earn the greatest number of VBP points. But the better question is, "For our hospital, out of all the measures that present opportunities for improvement, which are the best candidates for improvement initiatives?"

Under the VBP methodology, scores earned for each clinical measure are weighted equally in calculating the performance score. The same holds true on the HCAHPS side. So a measure earning a high number of VBP points will contribute more to the hospital's total VBP points than a measure earning a low number of VBP points. However, measures with low scores offer a high potential for earning points on improvement, which can drive higher VBP performance scores.

But consider, too, that quality improvement initiatives are expensive and time-consuming. Under VBP, the rewards for improving scores on a measure depend to a great extent on where a hospital's performance falls between the baseline performance and the benchmark and how far those two are apart. Knowing where higher scores will translate into higher VBP points will enable hospital leadership to be strategic in targeting the opportunities for improvement and deploying the necessary resources to attain goals.

Selecting Measures for Improvement

So here is some advice on where to focus improvement efforts to win under VBP:

- Assess your exposure. Examine your hospital's performance on each measure to determine which measures are driving the biggest losses. These become your hospital's candidate measures for improvement. Generally speaking, hospitals perform better on the clinical measures than they perform on the HCAHPS domains. As a result, there tend to be more dollars lost and therefore more opportunities to boost VBP scores by making improvement investments on the satisfaction side. That said, it also tends to be considerably harder to move the needle on the satisfaction measures than on the clinical measures.
- Identify candidate measures for improvement. Measures that have low mean scores and a wide distribution of rates offer the most opportunity for improvement. On the clinical side, the measures that meet that description include AMI 8A, fibrinolytic therapy and percutaneous coronary intervention (PCI) timing for patients with a heart attack; and SCIP measures addressing antibiotic timing after surgery.
- Bring in the experts. Engage your hospital's quality improvement, patient satisfaction professionals and other key stakeholders who readily understand that some aspects of care lend themselves more readily to quality improvement interventions than others and who can identify the effort required to improve candidate measures. Improving discharge instructions for heart failure patients is far less complicated than improving time-to-PCI, for example. Dissect your performance at the measure level, employing patient-level analysis to pinpoint and understand the factors that shape your hospital's rates.
- Use a return-on-investment approach to target specific measures. With the understanding that you can't improve everything at once, identify the potential rewards for improving or hitting the attainment threshold on each measure. Prioritize interventions according to size of the opportunity, the investment required and the net effect of incremental improvement on the bottom line.

With all the challenges of running a hospital today, leaders understandably prioritize their investment of time and resources. Given that payments aren't affected until fiscal year 2013, value-based purchasing may sound like a challenge that can be safely placed on a back burner. But like that car passing you on the right, VBP is closer than it appears. Recall that each measure is scored on attainment and improvement, and that scoring on improvement calls for comparing the hospital's rate in the performance period (July 1, 2011 - March 31, 2012) to a hospital's rate in the baseline period, which has already taken place.

Therefore, for all intents and purposes, VBP is already here, so now is the time to focus energy on winning back your full reimbursement under Medicare.

But Wait, There's More

Hospital value-based purchasing is just one piece of the Centers for Medicare and Medicaid Services' plans to shift from volume-based to quality-based payment. The Patient Protection and Affordable Care Act calls for additional programs to be implemented that also will put a portion of a hospital's Medicare revenue at risk, should the hospital's performance fall short of targets. While certain details about the scope and timeline of these initiatives have yet to be worked out, their overarching frameworks are well established.

All told, these programs will put (gulp) more than 7% of every hospital's Medicare payments at risk.

Hospital-acquired Conditions (HACs): Already hospitals are not reimbursed for certain preventable conditions acquired in the hospital. But beginning in 2015, CMS will rank hospitals on their risk-adjusted rates for certain HACs. Hospitals in the top quartile will be subject to a 1% payment penalty under Medicare. That means that 25% of all hospitals will lose 1% of their baseline MD-DRG Payments.

Readmissions: Beginning in 2013, CMS will rank hospitals according to performance on a 30-day readmission rate for heart attack, heart failure and pneumonia. Hospitals with excess readmissions will be subject to a 1% reduction in Medicare reimbursement. In 2015, the scope of diagnoses and conditions will expand to include chronic obstructive pulmonary disease, coronary artery bypass graft survey, percutaneous coronary intervention and other vascular conditions. Also in 2015, the penalty for excess readmission will have increased to 3% of Medicare reimbursement.

VBP Continued on Page 7

VBP Continued from Page 6

Meaningful Use: As part of the American Recovery and Reinvestment Act and further, defined by the Office of the National Coordinator of Health Information Technology, beginning in 2011 and continuing until 2014, hospitals will be eligible for incentive payments in return for demonstrating meaningful use of certified electronic health record technology, such as electronic prescribing. However, beginning in 2015, hospitals that fail to meet meaningful use criteria will be penalized. That penalty starts at 1% and increases to 5% by 2018.

Visit www.pressganey.com or contact Tina Minnick, 865.966.3280.

Red, Itchy, Watery Eyes? Sounds Like Pink Eye

Let's forego the medical niceties: pink eye is a sticky mess in your eyes – and it can hurt, too. If you have kids, you probably know it all too well because it spreads like the common cold. It is, after all, the most common eye infection in the country. The proper name for this improper condition is conjunctivitis.

Pink eye is an infection of the part of the eye called the conjunctiva. That's the clear membrane that coats under your eyelids and the whites of your eyes. Conjunctivitis can hit one or both eyes, and brings with it the telltale symptoms ranging from redness and itching to downright pain. And, with the bacterial kind, you get that stuff that seems to glue your eyes shut come morning. As with most maladies, bacteria, viruses or allergies are the cause. The trouble is how contagious pink eye is. If it hits one person in the family, it's likely to make its rounds to all family members.

Here's a rundown of the key symptoms and differences of the various forms.

Bacterial. It's the most common type and jumps from one person to another in a snap. The symptoms? Redness and itching and the sticky eyes that form at night, crusting over and keeping your eyelids stuck together by morning. Antibiotics can treat it.

Viral. Any number of viruses can cause it. Redness and itching are typical symptoms, as is the watery, clear discharge from the eye. Like the bacterial type, it's contagious. Don't bother with antibiotics. As with all viruses, they're useless against viral conjunctivitis.

Allergic. Just name an eye irritant and it can cause allergic conjunctivitis. Anything from dust and pollen, to chemicals like cleaners, perfumes and industrial pollutants, can irritate the delicate conjunctiva. In this form, eyes usually get red and swollen, and watering and itching can be severe.

Any of these symptom combinations should prompt you to call your eye doctor. If your case is bacterial, antibiotic eye drops may be prescribed.

"The most important thing is to get early treatment to limit the spread of the infection, especially among children," says Denis Humphreys, O.D., VSP doctor in Sparks, Nevada.

Pounce on Pink Eye

Dr. Humphreys shares some tips to limit the spread of bacterial and viral conjunctivitis:

- It'll be hard, but do your best not to touch or rub your eyes.
- Keep your hands clean, with regular washing and hand sanitizer.
- Keep your personal items to yourself. Don't share washcloths, towels or pillowcases. Wash everything after each use.
- Don't share eye drops.
- Eye makeup can harbor the infecting bugs, so throw out any mascara, eyeliner or eye shadow you've used since getting the condition.
- If you wear contact lenses, check with your eye doctor about not wearing them during treatment and/or replacing your lenses.

Visit www.vsp.com or contact Kandi Alyousef-Garza, 214.975.8011.

New Background Screening Website Launch

Information Solutions is the leading Arkansas-based pre-employment background screening company. It continues to dedicate itself to the medical community with specialized services for pre-employment background screening, OIG and other medical database searches. Information Solutions' new website is ready to go, and here is some of the new search content:

- **FDA Debarment**
  List firms or individuals convicted of a felony under federal law for conduct (by a firm) relating to the development or approval, including the process for development or approval, of any drug product, or otherwise relating to any drug product under the Federal Food, Drug and Cosmetic Act.

- **Texas Health and Human Services Commission Medicaid and Title XX Provider Exclusion**
  List of individuals and businesses excluded from participating in the Texas Medicaid, Title V, and Title XX and other HHS programs.

- **DEA Diversion Control Administrative Actions Against Doctors**
  List of administrative actions taken against physicians registered with the U.S. Drug Enforcement Administration to dispense or prescribe controlled substances.

- **FBI Crimes Against Children**
  Individuals wanted by the FBI for crimes against children.

  Includes:
  1) DOB
  2) Birth state
  3) Alias
  4) Hair/eye color
  5) Height, weight
  6) Sex, race
  7) Scars/marks
  8) Skin tone
  9) Photo

- **DEA All Divisions**
  DEA Most Wanted Fugitives.

  Includes:
  1) DOB
  2) Birth state
  3) Alias
  4) Last known address
  5) Hair/eye color
  6) Height
  7) Weight
  8) Race
  9) Sex
  10) Photo

- **Health & Human Services**
  The OIG, under Congressional Mandate, established a program to exclude individuals and entities affected by various legal authorities contained in section 1128 & 1156 of the Social Security Act and maintain this list of all currently excluded parties (preventing them from participating in federally funded healthcare programs). Basis for exclusion includes: convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

  Effects of exclusion are:

  1) No payment will be made by any federal healthcare program for any items/services furnished, ordered, or prescribed by an excluded individual or entity (Medicare, Medicaid.

  2) No program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services and anyone else. Regardless of who submits the claim!

  3) Limited exception for provision of certain emergency room items/services NOT provided in hospital ER.

- **Alabama Medicaid Exclusion List**
  Individuals and businesses excluded from participating in the Alabama Title XIX (Medicaid) program.

- **Connecticut Medicare Administrative Action List**
  State of Connecticut, Department of Social Services: Administrative Actions List.

- **Idaho Medicare Excluded Providers**
  Providers excluded by Idaho Medicaid. These providers or persons have been found to be involved in fraud or abuse.

- **FDA Clinical Investigators Restricted List**
  All clinical Investigators who have agreed to certain restrictions with respect to their conduct of clinical investigations.

- **FDA Clinical Investigators Compliance List**
  All clinical investigators who, under regulations in effect until 1987,

Search for Medical Partners Continued on Page 9

Search for Medical Partners Continued from Page 8

have provided FDA with adequate assurances of their future compliance with requirements applicable to the use of investigational drugs and biologics.

- **FDA Clinical Investigators Notice of Initiation**
  All clinical investigators who have received a Notice of Initiation of Disqualification Proceedings and Opportunity to Explain (NIDPOE) since 1998 are listed.

- **FDA Clinical Investigators Presiding Officer Report List**
  All clinical investigators who have received a Presiding Officer Report (recommendation to the Commissioner about whether to disqualify) and/or a Commissioner's Decision (final determination concerning disqualification).

- **FDA Clinical Investigators No Longer Restricted List**
  All clinical investigators who agreed to certain restrictions, which have now been removed.

- **FDA Clinical Investigators Disqualified List**
  All clinical investigators who have been disqualified or "totally restricted." FDA may disqualify a clinical investigator if the clinical investigator has repeatedly or deliberately submitted false information to the sponsor or, if applicable, to FDA. A disqualified or totally restricted clinical investigator is not eligible to receive investigational drugs, biologics, or devices.

Visit www.criminalscan.com for more information.

Arkansas Workers' Comp Dividends

The board of the Arkansas Hospital Association Workers' Compensation Self-Insured Trust met on July 29, 2011. After reviewing the financial solvency of each fund year since inception of the Trust in 2003, we are proud to announce the board voted to return anticipated unused premiums for the fund years of 2006 and 2009 to current members that were members of the Trust in each of those fund years, respectively. A total return of $200,000 for fund year 2006 and $300,000 for fund year 2009 was unanimously passed by the board. A percentage of the surplus has been returned to members based on each member's contribution to the surplus of each fund year. The contribution to the surplus is based on the premium paid and the incurred losses of each member.

The Trust is committed to providing a workers' compensation program of excellence, in which its members share the success and unused premiums. As a member of the Trust, controlling losses and maintaining an aggressive workers' compensation program in a proactive manner allows the Trust to return unused premiums to the member, as opposed to an insurance carrier that retains those profits for the company. Percentages of the Trust's income returned have averaged from 23% to 27% over the years while maintaining a healthy fund balance to meet our workers' compensation obligations. To date, the Trust has returned $5,821,164 to its members.

In addition to the approved dividend distribution, the Board voted unanimously to use the current rates now in effect for the 2012 fund year rather than increasing those rates as prescribed by the National Council on Compensation Insurance.

Hospitals interested in participating with the program should contact Tina Creel, vice president of AHA Services, Inc. at 501.224.7878. Or, contact Floyd McCann, RMR's Arkansas representative, at 800.690.4540.

AHA Services, Inc. Endorsed Companies

Amerinet - Group purchasing organization. Product standardization and utilization, financial tools beyond contracting and alliances that help lower costs, raise revenue and champion quality. www.amerinet-gpo.com. Rafael Rodriguez, NW AR, 877.711.5700, ext. 8029. Mike McGraw, 601.613.5477.

AUDIT Trax - Web based management tool for RAC audits. www.njha.com/hbs/audit-trax.aspx. Maureen Barrie, 609.275.4108.

BancorpSouth Insurance Services, Inc. - Liability insurance products and services, AHA Workers Compensation Self-Insured Trust. www.rkfl.com. Floyd McCann, 501.614.1179. Sherman Moore, 501.614.1183. Ray Robinson, 501.614.1139.

***Care*Learning.com** - Mandatory education including Health & Safety Compliance courses; Webinars - on-line, interactive courses; Competencies addressing core or discipline-specific education; Continuing Education toward licensure or various types of certification; Hospital-Specific Private Courses; Nursing Education. www.carelearning.com. Liz Carder, 501.224.7878.

***Care*Skills** - Competency Management System for workforce planning, employee selection, strategic learning, performance management, career development and succession planning. www.carelearning.com. Liz Carder, 501.224.7878.

ControlPay® Advanced - Earn monthly revenue share by replacing paper checks with electronic payment through the Visa®Network. Brandon Faircloth, 337.296.1420. Mike Simonett, 816.234.2565.

Denial Management Services - Manage QIO, MAC, CERT, RAC & Commercial Insurance, Admission Denials. www.fhahims.org. Barbara Flynn, 407.841.6230.

DocuVoice - Marketing/consulting company that specializes in outsourced coding/transcription solutions to address healthcare needs. DocuVoice's solutions also include ICD-10 assessment/training services, encoder software and Physician conducted chart reviews. DocuVoice's team works closely with you to design a custom program to address any of these areas by identifying your current situation at no charge. www.docuvoice.com. Bob Stewart, 615.275.7312.

Guldmann - Safe patient handling and moving; Ceiling-mounted lifts. www.guldmann.com. Marilyn Olson, 405.808.9211.

Hagan-Newkirk Financial Services, Inc. - Single source solution for employee benefit needs. Providing benefit design and consulting services, benefit enrollment solutions, custom employee education strategies, compliance assistance, wellness programs and payroll processing services. *Creditguard*. www.hagan-newkirk.com. Chris Newkirk, 501.823.4637.

HealtheCAREERS Network - Online recruitment, advertising and career solutions for the healthcare industry. Delivers content, job postings, news, events and career resources that are customized to a candidates' career path and relevant at every stage of their healthcare career. www.healthecareers.com/aha. Gary Seaberg, 214.256.4811.

Information Solutions - Instant criminal backgrounds, social security traces, motor vehicle records for all 50 states, credit reports. www.criminalscan.com. Sheila Moss, 479.263.0279.

Med Travelers - Temporary allied health professional staffing, temporary mid-level health professional staffing, locum tenens-allied health professionals. www.medtravelers.com. Landry Seedig, 972.830.4407.

Medefis - Vendor Management Solutions. www.medefis.com. Bryan Groom, 866.711.6333, ext. 114.

Merritt Hawkins - Permanent physician staffing, healthcare staffing, recruiting. www.merritthawkins.com. Harold Livingston, 214.801.3774.

nTelagent - managing accounts receivable with a total point-of-service solution. www.nTelagent.com. Jaclyn O'Neil, 225.933.7013.

Press Ganey - Satisfaction measurement (patient/employee/physician/home health), survey instruments, reporting and analytical tools, quality improvement solutions for HCAHPS. www.pressganey.com. Holly Horncastle, 888.300.4470.

Professional Data Services (PDS) - Revenue benchmarking for hospitals. www.pds-data.com. Leslie Gold, 213.283.8003.

Staff Care, Inc. - Locum Tenens-Physicians, temporary physician staffing. www.staffcare.com. Daryl Fowler, 469.524.1794.

VSP - Vision care. www.vsp.com. Kandi Alyousef-Garza, 800.638.2626.