



Experience well-balanced advice on the core issues you face from BKD National Health Care Group.

Selecting an electronic health record

by Rodney Walsh, rwalsh@bkd.com

The *American Recovery and Reinvestment Act of 2009* (ARRA) provides \$19 billion under Medicare and Medicaid in reimbursement for infrastructure and incentive payments for the acquisition and deployment of health information technology (HIT). These funds are available to prospective payment system and critical access hospitals, as well as physicians. The HIT deployed must allow the organization to become a “meaningful user” of HIT, which includes such criteria as using a certified electronic health record (EHR), information exchange, certified technology and reporting of quality measures. Financial penalties will ensue for those who are not meaningful users by 2015.

The challenge now is how to achieve the desired outcomes and return on investment envisioned for HIT. With many information technology projects, it is not uncommon for software to not be fully utilized or completely installed. Often the organization has spent so much time and energy on system selection there is

impatience to “go live,” causing implementation to be cut short. The regulatory deadlines could cause the implementation process to be rushed. The result can be inefficiency, increased costs, user dissatisfaction with the software and even an inability to demonstrate meaningful use.

Process equals outcome

Success comes from comprehensive planning, project management and implementation management, which includes appropriate senior leadership and key stakeholder involvement. Adoption of an EHR and related clinical systems is likely to require more systems resources, updates or changes to current HIT, increased attention to system security and controls (*Health Insurance Portability and Accountability Act of 1996* (HIPAA) compliance) and an increase in dedicated information technology (IT) staffing. A strategy to control the process, including the control of HIT vendors and your own internal constituency, will allow you to maximize the return on your HIT investment.

BKD recommends you incorporate the following five components into your HIT evaluation and acquisition process.

Support the process

The project and project participants must be supported by a management structure, which should include:

- A HIT steering committee: Comprised of senior management, clinical and HIT leadership whose goal is to blend business planning with HIT strategic planning
- HIT project teams: Tasked with using project management tools to accomplish specific aspects of the project

Assess readiness

To gain an understanding of the ability of your current systems and infrastructure to support an EHT/HIT system, as well as assessing your financial resources to do so, your first project steps should include:

- An ARRA reimbursement analysis – to estimate what you can expect

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the financial incentives and potential penalties to be for your organization

- A technical infrastructure inventory
- A security compliance and control assessment – to assess your compliance with best practices, HIPAA and the new HIPAA and breach provisions and penalties included in ARRA
- An assessment of your current software's compliance and a capability of supporting "meaningful use"
- Development of an HIT/EHR project charter so all participants are clear on management's goals

Document your needs

Execute a process designed to clarify and document your requirements for HIT, which may be as simple as the acquisition of additional modules for your current HIT or as extensive as replacing your key systems.

- Educate project leadership and participants regarding the current state of the HIT market and options
- Interview key stakeholders to define your specific needs, requirements and expectations
- Develop a request for information or request for proposal designed to convey your needs to prospective vendors and to quantify and compare vendor responses

Select a solution

The key to this step is controlling the process. Follow a structured evaluation and selection process using a needs-driven metrics.

- Perform a due diligence analysis of the top two potential vendors, including total cost of ownership
- Assess, negotiate and execute contracts, including appropriate docu-

mentation of implementation steps, responsibilities and expectations

Manage implementation

Utilize a project management office and structure process management tools to help ensure a successful implementation. This structure will allow you to:

- Manage the project, including management of your vendors, internal staff and external constituents
- Control changes to the original project
- Implement necessary process re-engineering
- Transition to ongoing vendor and systems management

Assistance is available

BKD can offer expertise in these HIT assessment and acquisition steps. Contact your BKD National Health Care Group advisor and let us assist you in meeting your HIT goals. ■

Shift to ICD-10 could be complicated; however, the new system is superior, helpful

by Paula Archer, parcher@bkd.com

Stop holding your breath; the wait for the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) is nearly over. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is finally nearing its 30-year-old term, which concludes October 1, 2013. That means health care providers can spend the next four-plus years preparing for the ICD-10.

Many in the industry are worried and full of dread about this transition, while many others are excited and relieved. After all, the World Health Organization (WHO) is already supporting ICD-10 standards, as are many other countries, including France, Australia, Germany and Canada. It is probably past time for the United States to come into the 21st

century and add its support for this set of standards, too.

The American Health Information Management Association (AHIMA) is probably the most pleased and excited; for years the organization has been a strong advocate of upgrading from ICD-9. The shift to ICD-10 and the resultant coding change will affect its largest single workforce group when it hits AHIMA's members. This workforce is spread throughout health care, working in hospital health information management (HIM) departments, information technology (IT), compliance, physician practices and payers only to name a few.

AHIMA anticipates the extra detail and specifics ICD-10 provides in its codes will lead to fewer denials and improperly reimbursed claims, reducing coding errors and increasing productivity.

In the Centers for Medicare &

Medicaid Services' ICD-10 Fact Sheet, the agency states "the new classification system provides significant improvements through greater detailed information and the ability to expand in order to capture additional advancements in clinical medicine."

The fact sheet also states ICD-10's increased specificity and clinical information will decrease the need to include supporting documentation with claims. It also will provide better data for developing payment systems, processing claims, identifying fraud and abuse and conducting research.

The level of detail ICD-10 will provide is overwhelming.

For example, with ICD-9, pressure ulcers are coded to only seven locations. ICD-10 includes 125 locations. A mechanical complication of a vascular implant or

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Does CMS have you “seeing stars?”

by Cindy MacQuarrie,
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Centers for Medicare & Medicaid Services (CMS) created the Five-Star Quality Rating System (Five-Star) “to help consumers, their families and caregivers compare nursing homes more easily and to help identify areas about which they might want to ask questions.” This Five-Star system rates nursing homes, and its purpose is to provide consumers with information about nursing homes in their state and to assist them with making a decision about placement in a nursing facility.

The system assigns one to five stars to every Medicare and/or Medicaid certified nursing home. Five stars is an indication the facility is above average quality compared to other nursing homes in the state. One star indicates the quality is much below the average in that state, while still meeting the minimum requirements for operating as a nursing facility. See Figure 1. The ratings are based on a bell curve, which means 20 percent of the facilities will receive one star, 70 percent of the facilities will receive two, three or four stars and 10 percent of the facilities will receive five stars.

Figure 1

What do the stars mean?

- ★★★★★ Much Above Average
- ★★★★ Above Average
- ★★★ Average
- ★★ Below Average
- ★ Much Below Average

Following the implementation of the Five-Star system in December 2008, many nursing facilities had questions and complaints about the data and its accuracy.

How it works

The Five-Star system rates the nursing facility on results of health inspections, staffing and quality domains:

Health inspections – The health inspection rating contains information from the last three years of onsite inspections, including both standard surveys and any complaint surveys.

Staffing – The staffing rating has information about the number of hours of care on average provided to each resident each day by nursing staff.

Quality measures (QMs) – The quality measure rating has information on physical and clinical measures for nursing home residents. The QMs offer information about how well nursing homes are caring for their residents’ physical and clinical needs.

Each facility is compared with all facilities within a state. The way the system is designed, only a certain number of facilities can be in the five-star category, four-star category and so on. Therefore, in any given quarter, only 10 to 12 percent of facilities can be a five-star facility.

State health inspections

The state health inspection forms the basis for the number of stars, with staffing and quality measures used to pull the

basic score in one direction or the other. For the state health inspections, points are assigned to deficiencies found in the three most recent annual inspection surveys. More recent surveys are weighted more heavily than earlier surveys. Each deficiency is weighted in scope and severity, ranging from A-L. See Table 1.

The star rating also is based on a facility’s relative performance within the state. Ten percent of the facilities with the lowest deficiency score receive five stars. The middle 70 percent of facilities receive two, three or four stars, with an equal number in each category. The 20 percent of facilities with the highest deficiency scores receive one star. A facility rating can change because of new surveys that will affect the statewide distribution.

Staffing

Studies conducted by CMS have shown an association between staffing levels and quality. Therefore, staffing is considered when determining the number of stars in the rating system. Stars for staffing are based on the facility staffing levels adjusted for resident acuity. The basis for the acuity is the resource utilization group (RUG) category (for both Medicare and Medicaid residents), as determined by the minimum data set

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Table 1

Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points (75 points) ¹	K 100 points (125 points) ¹	L 150 points (175 points) ¹
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points) ¹	I 45 points (50 points) ¹
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points) ¹
No actual harm with potential for minimal harm	A 0 points	B 0 points	C 0 points

¹ These indicate the points for deficiencies for substandard quality of care

Regulatory update

by Tim Wolters, twolters@bkd.com

The Centers for Medicare & Medicaid Services (CMS) released a number of regulations in late April and early May. While the regulations covered skilled nursing, inpatient rehabilitation and psychiatric units, the primary focus has been on the inpatient prospective payment system (IPPS) proposed rule for federal fiscal year 2010 (FY2010). As CMS believes the rate of increase in provider costs has slowed this year, the market basket update factors proposed for FY2010 are generally lower than for FY2009.

IPPS payment update

The proposed IPPS market basket update is only 2.1 percent, significantly below the 3.6 percent update for FY2009. To make matters worse, the impact of the proposed update is effectively eliminated by a proposed 1.9 percent documentation and coding adjustment (DCA). CMS is proposing this DCA as it believes hospitals have experienced increases in reimbursement under the MS-DRG system unrelated to severity of patient illness.

In fact, CMS believes the average hospital has experienced a 2.5 percent increase in case mix in FY2008, unrelated to patient severity. CMS reduced hospital payments by 0.6 percent during FY2008 to reflect the estimated growth in case mix and now proposes an additional 1.9 percent DCA in FY2010. CMS also believes hospitals have continued to experience case-mix growth in 2009 and believes an additional DCA would be warranted but has chosen not to propose an additional adjustment for FY2010.

However, it notes an additional adjustment of up to 6.6 percent may be necessary in the future to correct what it believes are excessive payments made to hospitals in FY2008 and FY2009. We suggest hospitals evaluate their own changes in case mix over the past two years and communicate to CMS other reasons, besides documentation and coding, for case-mix growth.

CMS estimates rural hospitals will experience an average decrease in reimbursement of 1.3 percent in FY2010, while urban hospitals will experience a decrease of 0.4 percent. Comments on the proposed rule are due by June 30, 2009.

Wage index issues

CMS continues to study the wage index used to adjust prospective payment rates. While no major changes are suggested for FY2010, the geographic reclassification changes initiated last year are proposed to be completed this year. This means for reclassification requests filed in 2009 or later, an urban hospital will need to show its average hourly wage (AHW) is at least 88 percent of its existing area's AHW, while a rural hospital must show its AHW is at least 86 percent of its area's AHW.

CMS also proposes to continue the transition from national to state-specific budget neutrality adjustments for the wage index floor, with a 50/50 blend in FY2010 and 100 percent state-specific adjustment in FY2011. CMS proposes to change the labor share of the standardized amount from 69.7 percent to 67.1 percent for areas with a wage index greater than 1.0. This will result in a slight reduction in payments for hospitals in such areas. Finally, three new metropolitan areas will be recognized in FY2010:

- Cape Girardeau, MO
- Manhattan, KS
- Mankato, MN

Rural hospital issues

CMS believes sole community hospitals (SCHs) and Medicare dependent hospitals (MDHs) have experienced the same growth in case mix as other hospitals and proposes a 2.5 percent reduction to their hospital-specific rates (HSRs) in FY2010. CMS had not imposed such a reduction in 2008 or 2009, as the law does not specifically authorize such a reduction in HSRs, but CMS believes it has the authority to make such a reduction as a special adjustment.

CMS reimburses SCHs and MDHs based on the higher of the federal rate or their HSRs. These can be computed from various years, most recently 2002 for MDHs and 2006 for SCHs. In computing the HSRs, CMS believes it should impose budget neutrality factors retroactively to 1993. These factors will result in the 2002 MDH hospital-specific rates being reduced by 1.7 percent starting October 1, 2009. The 2006 SCH HSR is reduced by 2.6 percent for fiscal years beginning on or after January 1, 2009. On the surface these retroactive budget neutrality factors appear unwarranted. We suggest all affected SCHs and MDHs consider filing appeals within 180 days of receiving notice of their applicable HSRs.

Due to a legislative oversight, CMS believes critical access hospitals (CAHs) that have elected the Method II billing option for outpatient services should not be paid 101 percent of cost for outpatient services, just 100 percent. CMS proposes to implement another legislative provision by reimbursing CAHs their cost for outpatient lab services (OLS), even if the specimen is not drawn at the CAH, as

long as the specimen is drawn by a CAH employee or the patient appears at the CAH for outpatient services on the same day. Skilled nursing consolidated billing rules apply for such OLS. CMS also proposes to apply the provider-based rules for OLS and seeks comments on whether such rules should apply to CAH ambulance services that are eligible for cost reimbursement.

Other IPPS issues

CMS proposes no significant changes to the hospital-acquired conditions that may affect a hospital's reimbursement. For 2010 quality reporting, CMS proposes eliminating one of the existing 44 reporting measures, combining two additional measures into one and adding four new measures, for a total of 46.

Another proposal would remove all observation days from the computation of the Medicaid percent used for disproportionate share reimbursement, regardless of whether the patient was admitted. However, maternity patients who have been admitted will be counted, regardless of whether they have occupied an inpatient bed yet. CMS clarifies that Medicaid patient days may be counted based on admission date, discharge date or service date, but hospitals wishing to change their method of counting days must notify Medicare at least 30 days before the start of the year.

For teaching hospitals, CMS implements the legislative requirement that 100 percent of the capital indirect medical education reimbursement be paid through September 30, 2009, but still intends to eliminate this reimbursement October 1, 2009. CMS also clarifies that a new medical residency program is one that receives initial accreditation for the first time, as opposed to reaccreditation

of a program that existed previously at the same or another hospital.

There are numerous other provisions affecting hospitals. Contact your BKD advisor for information on the impact

these proposed regulations may have on your operations. □

Other regulatory changes

Skilled nursing facility proposed rule – CMS proposes a 2.1 percent market basket update for SNFs effective October 1, 2009. However, this is more than offset by a 3.3 percent reduction due to a higher percent of patients scoring the new resource utilization group categories over the past few years. CMS anticipated 19 percent of patients to score in the new categories, but 30 percent have actually scored in these higher-paying categories. CMS proposes a new resource utilization group system in FY2011, increasing the categories from 53 to 66. CMS also proposes to eliminate the short-form minimum data set form available to swing-bed hospitals, increasing the information required to be accumulated on swing-bed patients.

Inpatient rehabilitation facilities proposed rule – Inpatient rehabilitation facilities (IRFs) would experience a 2.4 percent increase in their payment rates effective October 1, 2009. They also may receive higher outlier payments as CMS updates the outlier threshold in an attempt to increase outlier payments from 2.8 percent to 3.0 percent of total payments. CMS proposes a significant decrease to the rural add-on, resulting in an estimate that rural IRFs will see only a 0.7 percent average increase in reimbursement, while urban IRFs will see a 2.8 percent average increase. CMS also would require completion of the IRF patient assessment instrument for Medicare Advantage patients effective October 1, 2009. CMS proposes various changes to regulatory requirements, such as requiring weekly interdisciplinary team meetings (compared to the current biweekly requirement) and the rehabilitation physician must document concurrence with all decisions made at the meeting.

Inpatient psychiatric facilities notice – The inpatient psychiatric facilities (IPFs) notice of rates effective July 1, 2009, generally provides a 2.1 percent market basket update. CMS proposes a significant increase in the outlier threshold, from \$6,113 last year to \$6,565 this year, which will reduce IPF outlier payments. Otherwise, no changes are proposed to other adjustment factors, such as the rural, teaching, variable per diem, age, MS-DRG and comorbidity factors. □

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(MDS) assessment. Facilities that treat residents with higher acuity would be expected to have higher staffing levels.

Both registered nurse (RN) staffing hours per patient day and total nurse staffing hours per patient day are considered when determining the number of stars received. Actual facility staffing numbers come from forms completed as part of the survey process: CMS-671 (number and type of facility staffing) and CMS-672 (to determine the number of residents). The facility's staffing hours per patient day are determined by dividing the number of nurse staff hours by the number of residents. These numbers are then compared to the national benchmark, based on a CMS study conducted in 1997.

Scoring for the nurse staffing measure is distributed over five levels, based on national data. Facilities that meet or exceed both the RN and total staffing levels receive a five-star rating. Nursing homes are then assigned to the remaining levels proportionally downward, based on their score. These thresholds will remain constant for the first two years. Table 2 shows the rating based on the staffing. The facility can improve its staffing by increasing either the RN hours or total hours.

Quality measures

There are 19 measures used to evaluate quality nursing homes. The five-star rating uses 10 of these measures: Seven measures for residents with long stays and three measures for residents with short stays. See Table 3.

These measures are obtained from MDS assessments, using the three most recent quarters available. Points are assigned for each quality measure, based on the facility's quintile. Performance on the two activities of daily living (ADL) measures account for 40 percent of the overall weight on the long-stay measures. The quality measures are based on a national distribution, with the exception of

Table 2

Staffing Points & Rating

		Total Staffing (RN, LPN, Aide) per patient day					
		1	2	3	4	5	
Benchmark		≤ 2.998	2.999-3.376	3.377-3.842	3.843-4.079	≥ 4.08	
RN Staffing	1	≤ 0.221	1 star	1 star	2 stars	2 stars	3 stars
	2	0.222-0.298	1 star	2 stars	3 stars	3 stars	4 stars
	3	0.299-0.402	2 stars	3 stars	4 stars	4 stars	4 stars
	4	0.403-0.549	2 stars	3 stars	4 stars	4 stars	4 stars
	5	≥ 0.55	3 stars	4 stars	4 stars	4 stars	5 stars

the two ADL measures, which are based on the state quintile.¹ Those facilities in the top 10 percent receive five stars, the middle 70 percent - two, three and four stars, with an equal number in each category. The bottom 20 percent of facilities receive one star.

Overall nursing home rating —composite measure

When calculating the facility's overall score, the first step is to determine the score on the health inspection rating. Next, one star is added for a four- or five-star rating for the staffing domain or subtracting one star if there is a one-star rating for staffing. A facility receiving a two- or three-star rating in staffing is not given any additional points. The last step is to add one star for receipt of a star rating in quality measures and subtracting one star for a one-star score in QMs. Facilities that receive a two-, three- or four-star rating in QMs are not given any additional points.

What can be done to improve the star rating?

Any survey can change the rating. The staffing data is changed with the annual inspection. QMs are updated quarterly (January, April, July and October). There are definite steps that can be taken to improve the overall rating.

Surveys – Because the state health inspections are so important in determining the base number of stars, facilities need to be prepared for each inspection and promptly address issues that may prove problematic during the survey process. Focus on changes that can be made before the next survey.

MDS – The components for acuity and quality measures used in the Five-Star system are obtained from MDS data submitted to the state database. Review the MDS and QI/QM reports to ensure assessments have been completed appropriately, they reflect the level of care and services provided to the resident and the quality measures that result from the MDS are accurate.

Staffing – Compare current staffing levels with the CMS study (this is available on the CMS website). Calculate the RUG category for each resident. There are a specific number of minutes that have been estimated to care for a resident in each category. This will give the facility an "expected" staffing, based on actual resident needs. Is the resulting staffing number reasonable? Or, does the result seem lower (or higher) than the actual level of care required for the residents? If the staffing level seems too low or high, review the MDS to ensure it is accurately coded. Also, make sure to cross-reference the CMS-671 against the nursing home

compare website. Finally, check these forms before giving to the survey team. Other questions to consider: If the staffing measurement is appropriate, but is lower than expected, would it make sense to change the level of staffing to meet the benchmark? What would be the cost of increasing the staffing levels? Does that make sense in light of current reimbursement?

Quality measures – Review the QMs in the state database and evaluate whether these are a reflection of the resident's condition. If not, a correction of the MDS or completion of a change in status assessment may be necessary. Are you using the QMs as part of the facility's

quality improvement program? This will assist in preparing for the survey, as well as determining accuracy of the quality measures used for the Five-Star system.

Finding the ratings

Reviewing the CMS website to see how the facility is faring under the Five-Star system is important. Ratings are posted the middle of each month on the CMS website: <http://www.medicare.gov/NHCompare/Include/DataSection/Questions/ProximitySearch.asp>. A facility's rating may change every month, based on new data from other facilities in the state. Being proactive in recognizing issues, analyzing the underlying causes

and working toward improvement in the facility is the best approach in optimizing your facility's rating.

Right now, the rating system only compares facilities within a given state, as there is not yet a mechanism in place to compare quality of the facility in two or more states. Furthermore, both hospital-based units and free-standing skilled nursing facilities are grouped together, which could skew comparison because of difference in the patients treated in each type of facility. Currently, there is no appeals process for the Five-Star system when questionable, inaccurate or incomplete data have been identified. This has been a source of concern, and a procedural change has been requested by national provider associations. Facilities should be able to respond to misleading information resulting from inaccurate or missing data.

Contact your BKD consultant for further information and assistance in improving quality. ■

¹The two ADL measures will be updated quarterly, while the others will remain the same for the first two years.

Table 3

Quality Measures Used for the Rating System

Quality Measures for Long-stay Residents	Quality Measures for Short-stay Residents
Percent of residents whose need for help with daily activities has increased (ADL measure)	Percent of residents with pressure ulcers/sores
Percent of residents whose ability to move about in and around their room got worse (ADL measure)	Percent of residents with moderate to severe pain
Percent of high-risk residents who have pressure sores	Percent of residents with delirium
Percent of residents who had a catheter inserted and left in their bladder	
Percent of residents who were physically restrained	
Percent of residents with urinary tract infection	
Percent of residents with moderate to severe pain	

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graft currently has one code but will have 156 codes. Angioplasty currently has one code but will have 1,170 codes that will specifically indicate body part, the operative approach and device used. Of course, in order to be coded, this level of detail must be documented in the medical record.

Still, many in the industry are worried about implementing this new system. Some of that anxiety and dread may come from the potential costs associated with this industry-wide implementation. The *Rand Report*, March 2004, estimates the cost of implementation will range from \$450 million to \$1.115 billion (industry wide). The *Rand Report* concluded implementation costs will include training, lost productivity during implementation and system upgrades. However, the report also concluded benefits will exceed initial costs within a few years by providing more accurate payment, fewer miscoded, rejected or improperly paid claims.

Although four years away, do not procrastinate; prepare now. BKD recommends facilities begin with this proactive approach:

- Educate your IT department regard-

ing the upcoming changes to the code set requirements as outlined in the Final Rule, January 16, 2009.

- Perform ongoing coding audits to identify potential coding deficiencies that should be addressed with additional training.
- Because the level of specificity in coding is only as good as the documentation, evaluate your hospital's current clinical documentation improvement (CDI) program by performing coding and documentation audits.
- Establish a cross-functional work group to include IT, patient accounts and HIM.
- Create a communication process for continued awareness and ongoing updates.
- Develop a budget, including projected personnel and IT costs.
- Evaluate vendor capabilities and timelines.

Do not wait to begin the implementation process. Providers are concurrently implementing change processes around the recovery audit contractor (RAC) initiative, transition to Medicare

administrative contractors (MACs) and internal revenue management programs. With everything else on the agenda, it will take every available minute of the four-year transition period to make sure your health care facility is ready for ICD-10. ■

Health Care News

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