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## Patients in peril?

By **JODIE JACKSON JR.**

*Two recent reports found issues at **University Hospital** that could affect patient safety. But a disconnect between regulators means many safety concerns like these are not shared with other agencies — or with the public.*

Rusty drill bits. Several rusty knife handles. Single-use surgical towels used to soak up blood and other body fluids, then reused to wrap “sterile” surgical trays.

Those were among the findings at University Hospital during eight days of inspections by a Food and Drug Administration investigator between May and July 2008.

Two and a half years later, an inspection of the hospital by the Department of Health and Senior Services for the Center for Medicare and Medicaid Services (CMS) made similar finds: Residue and debris on instruments in sterile surgical containers. Orthopedic instruments with bone or cement on them. A sterile processing technician washing dirty surgical instruments with gloves on, then opening a door and answering a phone without removing the soiled, wet gloves.

The lengthy report from CMS dated Nov. 5 concluded “the cumulative effect of these systemic practices has the potential to affect all patients in the hospital.”

But three weeks before CMS inspectors began an unannounced, five-day visit to University Hospital, officials from the Joint Commission on Accreditation of Healthcare Organizations were on site to review the merger between University Hospital and the Women’s & Children’s Hospital, previously known as Columbia Regional.

On Nov. 10 — five days after CMS determined MU Health Care was not in compliance with standards of infection control and was in jeopardy of losing the ability to collect federal Medicare funds — the Joint Commission issued a report awarding the hospital full accreditation.

In fact, the Joint Commission granted its gold seal of approval, meaning the hospital meets or exceeds national standards in most areas.

In light of the divergent accounts, patient advocacy groups wonder why the reporting agencies don’t share reports with one another. Even MU Health Care administrators have said there appears to be a disconnect among regulatory agencies.

“I don’t think there is a real good system for sharing that kind of information,” said Becky Miller, director of the Missouri Center for Patient Safety. “I think there’s a long way to go to open up those communication lines.”



MU Health Care executives disagreed with several findings from both reports. MU Health spokeswoman Jo Ann Wait pointed out 18 months passed between the FDA's inspection and that report's release.

"No patients were harmed or in immediate jeopardy or they wouldn't have waited 18 months to get back to us," Wait said. She said the hospital was not asked to respond to the findings, but MU Health officials voluntarily sent a copy of their internal "FDA Action Plan" to the federal agency.

Through a Freedom of Information Act request, the Tribune obtained more than 400 pages of documents — including the hospital's action plan — listed as attachments or exhibits to the 24-page FDA report. Wait said hospital administrators have not seen those documents.

"That's part of the disconnect," Wait said. "We're not playing with the same deck of cards."

The Affordable Care Act, which aims to reform the nation's health care system, targets that disconnect to some degree. What patient safety advocates particularly like, however, are the new, phased-in reporting requirements that will require all hospitals and surgery centers to report hospital-acquired or health care-acquired infections.

Sharing information would go a long way toward improving hospital-acquired infection rates, said Lucian Leape, co-founder of the National Patient Safety Foundation. "Information from reporting systems ... is seldom used by regulators to improve safety," he said.

It seems clear the regulators aren't sharing information. FDA spokesman Christopher Kelly said his agency's reports are "sometimes" shared with sister agencies, but he could not disclose which reports are shared. CMS regional director Judy Baker said officials in her agency are addressing the communication gap internally.

And the Joint Commission learned about the latest CMS inspection and report from MU Health Care CEO Jim Ross. "They were surprised," Ross said during an interview last month. "They hadn't seen it."

The Joint Commission is not a federal regulator. Hospitals voluntarily choose to go through the agency's accreditation process, and there is no law requiring other agencies to share their reports.

"We would like to have the survey reports from CMS," said Patricia Kurtz, director of federal relations for the Joint Commission. FDA reports don't usually end up with Joint Commission inspectors. "We would like to receive those because those are part of our oversight fabric."

Some CMS regional offices are "very good" about providing the reports, she said. "Some regions are not so good," she said. "Some regions are horrible."

At the very least, the CMS and FDA inspection reports would be "very beneficial to the Joint Commission," she said, and could help target the commission's surveys of hospitals.

Kurtz said Joint Commission inspectors review more than a thousand requirements for accreditation.

"I'm surprised that we did not pick up these issues that the two federal bodies picked up," she said.

Elizabeth Eaken Zhani, media relations manager for the Joint Commission, said the agency can issue a "requirement for improvement" from the hospital. University Hospital has not received such a request for the FDA or CMS reports.

Carey Smith, MU Health's manager of regulatory affairs, said all complaints made by patients, employees and the regulatory agencies are taken seriously.

"We're always looking for ways to improve," he said, noting complaints often generate a task force or work group to address concerns.

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Hospital administrators continue to insist there was no evidence the hospital has an infection-control problem. In fact, data show MU Health, as well as Boone Hospital Center and Truman Memorial Veterans Hospital, are all doing as well or better than other hospitals across the nation in controlling infections.

"My wife actually had surgery here after this report," Ross said in the January interview, referring to the CMS report. "Our reputation about patient safety is everything."

Les Hall, MU Health's chief medical officer, provided information to show the hospital's rate of staph infections has declined dramatically each year since 2002. Hall also pointed out the health system had implemented corrective action on all the CMS findings, even though Ross said his administrative team did not agree with all the findings.

For instance, Ross said, his team agreed some casters on medical equipment wheels were rusty, but he said that did not affect patient health and "outcomes," such as infection rates and hospital readmissions. The report also detailed findings of food on the floor and in the corners of food preparation areas.

Ross called some of the CMS observations "awfully granular."

Even though MU Health officials disagreed with several of the CMS findings, hospital staff responded with a massive deep-cleaning of the hospital in December. Some 120 employees worked overtime or volunteered to help housekeeping staff with the cleaning effort. An additional 25 housekeeping crew members were hired as a result of the CMS inspection.

The voluntary action plan in response to the 2008 FDA report, while not agreeing with most of the specific findings, called for discarding old instruments and instruments with rust or debris and removing instruments that could be mistaken for single-use devices. The plan also outlined improvements in record-keeping, training for employees in the sterile processing department and improved tracking of equipment repairs and maintenance.

Wait said MU Health spends some \$4.6 million annually to support specific efforts to boost health care quality.

Hall pointed out University Hospital, in particular, treats "the sickest of the sick," because patients are often transferred there from other hospitals. Those patients often already have compromised immune systems and are at a higher risk for complications or infection.

Marcia Patrick, director of infection prevention and control for MultiCare Health System in Tacoma, Wash., agreed hospital patients are already more vulnerable to certain infections because of pre-existing conditions such as diabetes, malnutrition or dirty wounds. "That makes it very hard to prevent infections," she said.

Patrick, who is a board member with the Association for Professionals in Infection Control and Epidemiology Inc., or APIC, said it's not good enough, though, for a hospital to say it is "average" in terms of infection control.

"Hospitals say, 'Look, we're doing really well. We don't have a bunch of infections. We're better than the national average,'" she said. "Average is nothing to brag about. Average isn't good enough, especially in the area of infection control. We're all aiming for zero."



As for the scathing inspection reports from the Food and Drug Administration in 2008 and the Centers for Medicare and Medicaid Services in 2010, hospital administrators point to the CMS finding that the complaint that initiated the November inspection was "unsubstantiated with related deficiencies." Ross and Hall insisted patients were not harmed even by the "related deficiencies" in poor housekeeping and sterilization.

Even so, FDA and CMS each pointed to deficiencies that resulted in "dirty" surgical instruments in 2008 and 2010. Both reports also pointed out a lack of documented tracking of instruments, miscommunication between supervisors and staff, and similar issues that apparently allowed the deficiencies to persist.

"It does sound like there are system problems, and hopefully those have been addressed," Patrick said.

She said it was probably easy for inspectors to find problems because they were tipped off "and went in there with laser vision."

Hal Williamson, vice chancellor for the University of Missouri Health System, said CMS inspectors combined to spend 312 hours on site. "They had a lot of stuff to work with," he said.

Williamson said he did not necessarily agree with all the findings and was puzzled about why CMS made the report public before giving MU Health Care an opportunity to respond with a plan of corrective action. CMS officials said it was unusual for that to happen.

Without the tip from former sterile processing technician Sam Backues, neither the regulatory agencies nor the public would have known about the problems. Backues, who was the only certified sterile processing technician on his shift — and who was identified by his immediate supervisor as a possible trainer for other technicians — notified the FDA about the problems in May 2008. Backues also made contacts that led to the CMS inspection in November.

Hall said hospital policy encourages employees to "speak up," especially in the area of infection control.

"He did raise the issue when he was employed here," Ross said. The hospital's infection control department conducted an internal investigation and "did not substantiate his complaint."

Backues worked the fourth and final stage of the sterilization process. He cited faulty washing and drying machines as the main reason instruments were still embedded with bone or tissue when they reached his station.

"There was literally blood running out of the" surgical "tray when it came out of the washer, and it was cold," Backues said. He provided several copies of work orders for the department's equipment. The FDA report noted the equipment problems.

He filed a complaint with FDA on May 1, 2008, claiming the sterile processing department was routinely reprocessing devices meant to be used only once. The other claim that caught FDA's attention was his observation of "dirty" orthopedic implant parts that had been sterilized.

Backues recalled the visit from FDA inspector Monique Brooks. Brooks asked technicians whether single-use devices were being reprocessed. Other staff members said that was not occurring. However, Backues not only confirmed it, he also told Brooks where to find the devices. Her subsequent report confirmed his claim.

Within an hour of his on-site conversation with Brooks, Backues said, he was summoned to the office of Director of Surgery Mark Jackson "to talk about my employment with the university."

University officials have not responded to that claim. Brooks' report includes affidavits from at least two other employees who feared retaliation if they spoke out about the sterile processing department. Brooks also noted that concern in her report.

The discussion between Backues and his supervisors took place two weeks later, with a union representative joining the meeting on behalf of Backues. He eventually transferred to other areas of employment within the university system. He voluntarily left in January 2009.

Backues also made the complaint that led to the CMS inspection.

"As far as direct observations, he has not been here on-site in the last two and a half years," Ross said last month.

Actually, Backues next worked as an independent contractor providing courier services for Guardian Medical Logistics in Columbia. In August, he delivered used vaginal speculums and other instruments from MU Health's Smiley Lane clinic to the hospital's sterile processing department. Backues said he was instructed to take instruments through the "clean," or sterile, side of the department.

"I knew then nothing had changed with management's attitude toward cleanliness," he said. "They were still running dirty."

He phoned in a complaint to the hospital's infection control department that day. By then, he also had a copy of the 2008 FDA report, which he circulated to local media and other parties, including the attorney general's office.

Backues said he was contacted by state Department of Health and Senior Services officials to get more information. At that point, Backues filed an official complaint, which led to the CMS review in November.

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Hospitals want the public to keep the reports in the context of the overall work they do. Every day, about 120 surgical procedures are done in Columbia's three hospitals. In the vast majority of cases, nothing goes wrong.

Finding information about the cases that go wrong can be cumbersome, and scant details are available. For instance, a national tracking service shows some 6,000 medical malpractice reports in Missouri since 1990. The list includes 4,158 medical doctors, 696 osteopaths and 604 dentists. But no names or other identification are listed. Another report lists thousands more "adverse action reports" by licensing

agencies against nurses, athletic trainers, chiropractors, pharmacists, professional counselors and social workers, speech pathologists and doctors.

Discipline reports are often available online from the licensing agencies, but without knowing which names to look for, matching those reports with the national database is virtually impossible.

When it comes to information related to preventable medical errors — including hospital infections — the public is usually in the dark. Until now. Health care reform legislation has established a timetable for meeting infection reporting requirements.

"Most hospitals already have this information," said Lisa McGiffert of Consumers Union, "but if they never put it together for the public in a meaningful way, it might as well not be there."

Lawmakers passed the Missouri Hospital Infection Control Act of 2004 that required hospitals to report their rates of specific infections, but patients must know how to navigate specific websites to find the information. MU Health officials said this week their patient safety data will soon be on the university's website.

"University of Missouri Health Care is committed to providing our patients with the safest, highest-quality, most-satisfying care possible and to transparency in sharing our quality data with the public," the university said in an e-mail response to a series of questions. "Recognizing that this information needs to be understandable and user-friendly, we are in the process of developing our own Web site for reporting this information."

Herb Kuhn, president of the Missouri Hospital Association, agreed hospitals should do a better job of making their data understandable.

"It's kind of like the airline industry. We don't hear about all the near-misses and activities," said Kuhn, a former deputy administrator for CMS. "You don't want to create a chilling atmosphere."

He also pointed to a recent study that showed CMS has withheld only \$20 million of \$150 billion paid to hospitals as a result of hospital-acquired infections.

"I think a lot of people were surprised," Kuhn said. "The number of incidents that occur is quite small."

He quickly added: "Each and every one of them should never, ever happen."

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## Hospital infections seen as 'winnable battle'

Prevention is an increasing focus.

By **JODIE JACKSON JR.**

To get an indication of the national magnitude of hospital- or health care-acquired infections (HAIs) consider the short list of "winnable battles" championed by Thomas Frieden, director of the Centers for Disease Control and Prevention.

The list includes reducing death and disease caused by tobacco; reducing new HIV infections, taking steps to drive down motor vehicle injuries; promoting nutrition and physical activity to stem the tide of obesity; improving public health through food safety; preventing teen pregnancy — and eliminating preventable health care-associated infections.

"There has been a big increase in focus on infection prevention," said Marcia Patrick, director of infection prevention and control at MultiCare Health System in Tacoma, Wash. "That's wonderful. That's where we want to go."

Patrick also is a board member for the Association for Professionals in Infection Control and Epidemiology Inc., an international organization with its sights set on infection and disease.

Officials at Columbia's hospital systems say their facilities have internal infection-tracking methods and are committed to following CDC guidelines for reducing HAIs.

Boone Hospital Center staff members wear a name badge that lists the hospital's "10 Standards of Excellence." At the top of the list is "patient safety."

"Patient safety and infection control are central to our hospital's mission of improving the health of the people in the communities we serve," Boone Hospital media relations specialist Jacob Luecke said. "We take this mission very seriously and focus a great deal of time and resources on ensuring our patients' safety."

But Luecke said Boone Hospital does not publicly disclose its internal tracking of safety measures.

"I can tell you that we measure widely, set the bar high and expect improvement each year," he said. "Our most recent results show we are among the top achievers in this regard."

**University of Missouri Health Care** has had its Office of Clinical Effectiveness since 1997. MU Health spokeswoman Jo Ann Wait said the office has "the singular purpose of improving the quality and safety of patient care" in the hospital's system.

Wait said the hospital's infection rates, which are publicly reported for surgical site and bloodstream infections, "provide strong evidence of the effectiveness of our patient safety and infection control practices."

MU Health and Boone Hospital have new patient care towers under construction. Hospital officials said the additional rooms will enhance safety by allowing more private rooms, which control the spread of infections.

Even with increased focus on HAIs, nearly one in every 20 people who get hospital treatment — up to 2 million people a year — get an infection as the result of treatment. As many as 99,000 will die. The CDC estimates the cost to the health care system is between \$35 billion to \$45 billion annually.

The Agency for Healthcare Research and Quality reported an 8 percent increase in bloodstream infections over the past year. The agency estimated that more than 30,000 people die from bloodstream infections they get from being in the hospital.

Surgical sites, central lines, catheters, intravenous lines and wound care are common avenues for carrying infection. But the vast majority of HAIs are caused and spread by the most common instrument used in hospitals — the human hand.

In addition to hand hygiene and quality-checked sterile processing methods, providing surgical patients with antibiotics before surgery is an important anti-HAI measure.

A November report by the Joint Commission for Accreditation of Healthcare showed that University Hospital met or exceeded national standards in almost all performance categories. Still, the report, which is based on statistics collected from March 2009 to April 2010, showed the hospital lagged behind national averages in some areas. Seventy-three percent of patients received the appropriate medication for colon and large intestine surgery, versus the national average of 89 percent, and 82 percent of adult pneumonia patients were given antibiotics within six hours of arriving at the hospital, versus the national average of 95 percent.

Wait said MU Health officials were working to address those statistics.

Other factors that increase the risk of an HAI include: age, disease history or underlying disease, inadequate nutrition, compromised immunity and trauma.

Any unnatural intrusion of the body can introduce infection. For instance, the respiratory tract has a number of defense mechanisms to protect the body: saliva, the cough and gag reflex, and the cilia lining the respiratory tract. An endotracheal tube — a temporary breathing tube to keep the airway open — bypasses those defenses. Another example of a medical procedure that bypasses the body's natural defenses is a needle-stick that can introduce a variety of blood-borne pathogens.

Some of the more common — and potentially lethal — types of health care-associated infections that must be reported to state and federal regulators include:

PCentral line-associated bloodstream infection (CLABSI). A central line is a tube that health care providers place in a large vein in the neck, chest or arm to give fluids, blood or medications or to do certain medical tests quickly. When germs enter the bloodstream via a central line, a variety of complications can occur. A CLABSI is the most expensive health care-associated infection to treat and heal.

PSurgical site infection (SSI). Sometimes an infection occurs after surgery in the part of the body where the surgery took place. SSIs are sometimes nothing more than superficial infections of the skin. Other SSIs are more serious and can involve tissues, organs or implanted material, such as orthopedic parts for shoulder, knee and hip surgeries.

PCatheter-associated urinary tract infections (CAUTI). A catheter is a tube inserted into the bladder to drain urine. These infections can affect the bladder and the kidneys when a catheter carries germs into the urinary system. A CAUTI is considered the least expensive health care-associated infection, adding an average of an extra \$1,000 to the patient's bill.

PVentilator-associated pneumonia (VAP). Hospitals report data called "head of bed" to show what percentage of patients on ventilators have the head of their bed elevated at least 30 degrees. That seemingly simple measure is seen as the main safeguard against VAP, which is a lung infection that develops in a person who is on a ventilator.

Health care consumers who want to find the infection rates for Missouri hospitals won't find how often "superbugs" — those drug-resistant bacteria — or similar germs make patients sick. The rates of infections caused by antibiotic-resistant organisms are not collected for public reporting by the Department of Health and Senior Services.

That decision makes patient safety advocates take notice. "It takes resources" — manpower — for a hospital to track and report every infection, Patrick said. "You can't do it if you don't have the bodies."

The "superbugs" include:

PMethicillin-resistant staphylococcus aureus, or MRSA, a common germ that can cause serious infections and pneumonia. MRSA is resistant to many of the antibiotics that are used to treat other staph infections.

PClostridium difficile, or C. diff. This bacterium can occur as a result of prolonged use of antibiotics during health care treatment. C. diff infections cause diarrhea and more serious intestinal conditions such as colitis. Contaminated surfaces and spores of the germ can cause C. diff to spread quickly throughout a health care facility.

Helen Haskell is a mother-turned-activist whose campaign has led most hospitals to ensure that patients and their families have the right to consult with a senior physician rather than an intern or a resident doctor. She advocates for more transparency in medical error and infection reporting and encourages patients to be more of a participant in their care than a spectator.

"There are so many questions that patients ought to ask. You're in a very vulnerable position" as a patient under the care of a doctor. "You're asking someone to do something very serious that you don't know anything about. You have to trust them."

Haskell, the founder of Mothers Against Medical Error, insists that patients and their families check the background of doctors and hospitals before getting treatment. She founded MAME 10 years ago after a series of preventable medical errors at a South Carolina hospital led to the death of her 15-year-old son, Lewis Blackman.

Health care-acquired infections are usually considered "no pay events" by CMS, so there's an added financial incentive to hospitals for reducing or eliminating the infections. "No pay events" are not the same

as "never events," which are surgical mistakes and errors in medical tests or medication. A series of "never events" killed Lewis Blackman.

The National Quality Forum, a Washington, D.C.-based not-for-profit group, has developed a list of "never events" — 27 incidents, such as wrong-site surgery, that should never happen in health care.

The list includes surgery performed on the wrong body part, surgery performed on the wrong patient, infant discharged to the wrong person, patient suicide, patient death or serious disability associated with a medication error, patient death or serious disability associated with a burn or a fall associated with medical treatment, abduction of a patient, and sexual assault.

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## University system hosts statewide public forums for presidential search

By Associated Press

4:02 a.m. CST, February 28, 2011

**COLUMBIA, Mo. (AP) — A series of statewide meetings designed to seek public comments on the University of Missouri system's presidential search begins this week.**

The first session takes place on Thursday morning at the Delta Center in the southeast Missouri town of Portageville. Subsequent meetings are planned for March 7 at the university's St. Louis campus; March 8 at Missouri-Kansas City and Missouri Western in St. Joseph; March 14 at the Columbia campus; and March 15 in Rolla and Springfield.

The public comments will be limited to the preferred traits of the university's next leader rather than directed toward specific candidates. That process will not involve public input.

University curators are seeking a permanent replacement for Gary Forsee, who stepped down in January to care for his ill wife.



## University of Missouri president's home questioned

By: The Associated Press 02/28/11 7:54 AM

*The Associated Press*

**The house where the University of Missouri president lives is a mansion, complete with a swimming pool and surrounded by woods.**

But some are wondering whether the university's next president should live in the home, known as Providence Point.

Interim President Steve Owens says the building is a hybrid of a home and a site for official events, and it doesn't do either one well. He says it's a good time to discuss whether the next president should live at the house.

Owens says if the president didn't live in the mansion, the university system would provide some sort of housing allowance. He tells The Columbia Tribune that Providence Point could still be used for other public events, or as a residence for visiting professors.



## UM considers future of home

Residence may not be used for leader.

By **JANESE SILVEY**

At the end of an inconspicuous road that winds behind the University of Missouri's athletic complexes is the house reserved for the president of the UM System.

By real estate standards, the home known as Providence Point is a mansion. The 12,630-square-foot dwelling has several dining and living areas, four fireplaces, eight bathrooms, four designated bedrooms and a lot of other rooms that have served as office and exercise space over the years.

A swimming pool in the middle of a large wooden deck and a rooftop patio perfect for sunbathing also are perks at Providence Point. And it's all surrounded by a wooded landscape tucked back just far enough to be hidden from the sight of the sports fans heading to games and events at nearby arenas. But what some might see as the property's best features, others consider its worst.

The public sections of the home aren't really large enough to host the kinds of crowds presidents might like to host, and the way those rooms connect pose some traffic flow problems, interim President Steve Owens said. On the flip side, the formality of the residence doesn't exactly translate into a warm, homey feel.

"Some people believe it's a nice structure, a nice hybrid that can host official functions and also serve as a residence," Owens said. "Others believe that, because we've tried to make it a hybrid-type building that does both, we got neither accomplished."

And that wooded privacy that creates a serene daytime setting? Not only can it easily turn into spooky seclusion when, say, a president's wife finds herself alone there at night, it also serves as habitat for deer, opossums, skunks and other critters that have proved to be a challenge for family pets, system spokeswoman Jennifer Hollingshead said.

Bottom line, the next UM System president might not want to reside in the official university mansion.

Owens has started to question whether it makes sense for the university to maintain the president's home. Gary Forsee, who resigned in January, moved out earlier this month, and now, when the house is vacant, is the best time to analyze the situation, he said.

Unlike the chancellor's residence on Francis Quadrangle at MU — a nearly 150-year-old structure that's hosted Mark Twain, Harry S. Truman and Eleanor Roosevelt — Providence Point lacks historical significance. Sure, all eight presidents have lived there since it was built in 1971, but it hasn't hosted many notable guests, other than a handful of Missouri politicians. The property also got some not-so-

flattering publicity in 2003 when former MU basketball player Ricky Clemons wrecked an ATV there during a party hosted by then-President Elson Floyd.

The house's design is one-of-a-kind, though — so much so that there's no appraisal because there aren't comparable homes, Owens said. The public spaces, on either side of a main foyer, include a dining room that comfortably seats 16 and another living space that can be set up for larger gatherings.

A spiral staircase leads to a large bedroom upstairs, and additional rooms and offices are downstairs. A long, narrow hallway leads to the private quarters; essentially a second home added on in 1985, said Ashley Rhode, a special events coordinator and property manager who took the Tribune on a tour of Providence Point last week.

Although the house and subsequent addition were built using private funds, upgrades and maintenance costs come from the university's budget. Most recently, the Floyds upgraded the kitchen in 2005, and the Forsees added a gate and security system in 2008. Owens thinks offering up the home to the next president would require some additional maintenance and repairs.

Even if that person didn't live at Providence Point, though, the system would still provide some sort of housing allowance, a common practice in higher education, Owens noted. If that were the case, he said the president's home could be used for some other public purpose or, perhaps, as a residence for visiting professors who spend a semester or two at MU.

"The next president is going to come in and, if offered, decide whether to reside in Providence Point or somewhere else," Owens said.

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# COLUMBIA MISSOURIAN

## **UM System plans to reinvest tuition increase in financial aid**

By Alex Keckeisen

February 25, 2011 | 3:38 p.m. CST

**COLUMBIA – With expected tuition and fee increases in 2012, University of Missouri System campuses want to pump a portion of that money back into financial aid for students.**

**UM System administrators set a target of 20 percent of revenue from the 5.5 percent tuition and fees increase to be used for financial aid in fiscal year 2012. The tuition increase was approved by the UM System Board of Curators in January.**

Each of the system's four campuses will allocate the financial aid to meet student needs.

MU plans to allocate the reinvestment money to automatic scholarships, need-based aid and matching aid received from the federal government for two programs, Federal Supplementary Educational Opportunity Grant and work study, according to Jim Brooks, director of student financial aid.

In 2011, student financial aid at MU totaled \$112 million, according to the MU Budget Office website.

Reinvestment of tuition increases in to aid is a common method used by the UM System to increase financial assistance.

“Our four campuses work very hard with students to help them stay in school and come to school, and we use our financial aid awards to help make that possible,” said Nikki Krawitz, UM System vice president for finance and administration. “The goal is to make affordable education for students.”

The tuition increase is pending approval by the state Department of Higher Education, which requires the system to submit a waiver to increase tuition beyond the rate of inflation. The waiver has not yet been approved.

MU could see an increase of approximately \$13 million in revenue generated from the 5.8 percent tuition and fees increase. From that revenue, \$2.7 million would be put toward financial aid.

Chancellor Brady Deaton will also allocate \$1.5 million more to financial aid for enrollment growth. With no tuition increases over the past two years, Deaton has designated increases to financial aid to cope with more students needing financial assistance.

"There was some additional money added to the scholarship budget because we were trying to stretch dollars farther," Brooks said.

According to Krawitz, 76 percent of students on the system's four campuses require some type of financial aid. Student needs are calculated on the Free Application for Federal Student Aid form. From there, financial aid offices on the system's campuses review the applications and decide which students will receive assistance, Krawitz said.

The Free Application for Federal Student Aid priority deadline is March 1, and the information will give financial aid offices an early understanding of student finances. The MU Office of Financial Aid wants to have financial aid packages available to first-time students by April 1.

"It puts some of the tuition increase back into the aid program to help students that may not otherwise have options to pay the tuition increase," Brooks said.

Sticker price versus actual cost is the focus for Krawitz. In her presentation to the curators in January, she said the sticker price of \$8,917 for tuition and required fees is not indicative of what the student often pays. The average student at MU is projected to receive \$4,107 in grant aid, or 46.1 percent of tuition and required fees.

In 2010, students across the system with family incomes of less than \$40,000 had 88.9 percent of their tuition and fees paid for with financial aid.

## COLUMBIA MISSOURIAN

# MU Faculty Council holding forum to debate grievance policy

By Michael Davis

February 27, 2011 | 9:25 a.m. CST

COLUMBIA — After a two-year trial run of a new grievance policy, faculty will be able to weigh in with their opinions on Tuesday.

**The MU Faculty Council will stage a faculty forum from 3:30-5 p.m. in Chambers Auditorium, Missouri Student Unions.**

**A pilot program was developed in 2008 to address procedural concerns by faculty members, Faculty Council Chair Leona Rubin said.**

Issues centered on the length of the process, difficulty seating a grievance panel and the stage of review by the chancellor.

One essential difference between the old and new processes is the point where a grievance is sent to the chancellor for review.

The old process began with the chancellor reading a grievance, then sending it to a standing faculty grievance committee to decide if it should be pursued. Once evidence was gathered by an investigator, the information was sent to a faculty hearing panel to make a recommendation to the chancellor for a final decision.

The new procedure still gives the chancellor authority to rule on a grievance, but now the grievance goes immediately to a resolution panel with two senior-tenured faculty members and one upper-level administrator for review.

Before an investigation, the panel attempts to mediate an informal resolution. If a resolution cannot be reached, evidence is collected and a recommendation forwarded to the chancellor.

The main area of contention with this pilot process has been the addition of an administrator to the grievance resolution panel, Rubin said.

“This is an opportunity for people who don’t like the policy to speak up and talk about their concerns,” she said.

To protect the interests of the faculty members and promote fairness, the pilot program created an oversight committee. One member of the three-person oversight committee is present for every meeting of the grievance panel to record all actions and provide an ongoing report to the council and ultimately the faculty.

In an October 2008 *Missourian* article, Laurie Mintz, former investigative officer for the grievance process, called the committee a “safeguard” to the process.

Before the pilot program was endorsed by the council in the fall of 2008, the grievance process was more onerous. Rubin said grievances would take one to two years and often end with both parties getting angry.

The efficiency of the process has improved, she said. The panel now requires that each grievance be handled within a span of three months.

Rubin said that she hopes issues such as the composition of the panel will be addressed on Tuesday. So far, those who have been loudest are opposed to the new policy, Rubin said.

“An awfully lot of the faculty that are happy with this process are not being vocal,” she said.

Members of the Faculty Council, the grievance oversight committee and the grievance review panel will be on hand Tuesday to answer faculty questions, Rubin said.

The UM System Board of Curators needs a recommendation from all four campuses to accept the new policy or discard it and return to the old process.

The University of Missouri-Kansas City and the University of Missouri-St. Louis have already voted to use the new pilot process on their campuses, Rubin said.



## O'Brien urges leadership

Anchor for CNN shares wisdom.

By **KRIS HILGEDICK**

CNN correspondent Soledad O'Brien talked about the meaning of leadership, the legacy of Martin Luther King Jr. and how hard work and perseverance have shaped her career in a lengthy keynote address last night.

More than 1,300 people gathered to hear O'Brien speak at Jesse Auditorium. About 700 were students from across the nation who are in Columbia to participate in the Big 12 Conference on Black Student Government.

O'Brien told listeners true leadership is about developing the "moral authority" that compels others to follow.

"It's about serving. ... Service is the highest form of respect. If you can be of service, there's nothing else to aspire to," she said.

O'Brien said her mixed-race parentage — her father is a white Australian and her mother is a black Cuban — inspired her to succeed despite racial adversity early in her career. Racism isn't as blatant today, she said.

"Today you might hear 'You're not a good fit for this organization' or 'Your values don't match what we're looking for,'" O'Brien said.

But she exhorted students not to waste their energies worrying about glass or concrete ceilings.

"It will do you no good," she said. "Just go and do a good job."

She said she made herself invaluable to her bosses by cheerfully taking every assignment tossed her way. Her first live shot was a disaster and her news director wanted to fire her, but she went to every 3 a.m. five-alarm blaze for years to rebuild her credentials as a competent reporter.

"By the 100th I was the best," she said. "What you can do is do your job really, really well."

She said she was always struck by the simplicity of King's message, which still has the power to inspire 43 years later. She said many people treat King as an "anointed leader."

"But as I have learned from doing several documentaries on Dr. King, the real power is that he was a regular man," she said.

O'Brien said she once had the opportunity to hold and pour over a sheaf of his papers while reporting from Atlanta. It was a chance for her and other researchers to notice the annotations he added as he read

books and wrote and edited his speeches. "The annotations were spellbinding," she said. "I got to see where anger gave way to hope, where optimism prevailed and where dreams emerged."

She said the experience taught her that individuals can make a difference, and she asked students to step forward and be the change they want to see in the world.

"The great takeaway for me — in reading and touching and holding his works — is that just about anybody can do great things, if you want to," she said.

At the end of her speech, dozens of students queued up to ask her questions.

Jamal Andress, a 21-year-old broadcast major at MU, asked her how to repair the self-enforced segregation on campus. She rejoined his question with a question of her own: "What are you going to do about it?"

She suggested Andress is well-positioned to solve the problem. "You should do a show about it or pull together a panel," she said.

Andress left the room promising to follow through on her suggestion. "Everyone left having a good feeling about the future and what they could do," he said.

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# House considers repeal of minimum wage law

Measure would nix adjustment.

By **RUDI KELLER**

JEFFERSON CITY — After a year in which gasoline prices in Missouri fluctuated around \$2.60 a gallon, fuel prices have spiked nearly 60 cents since Jan. 1, including about 25 cents in the past week.

Whether consumers are facing sustained higher prices this year is open to speculation. But fuel prices are built into the cost of every purchase and some things heavily dependent on fuel, such as airline tickets, already are subject to surcharges.

This week in the Missouri House, lawmakers will consider a bill to repeal a law enacted by voters in 2006 that protects the state's lowest-paid workers from the impact of inflation.

The bill would require that Missouri's minimum wage never exceed the minimum set by the federal government.

Supporters of the change argue that it will protect businesses from forced increases in labor costs and preserve jobs for low-skilled workers.

"I think that anytime you have a built-in response that doesn't take into account market factors that are a legal restriction, you are going to make society worse off," said economist **Joe Haslag, who holds the dual roles of executive director of the Economic and Policy Analysis Research Center at the University of Missouri and chief economist at the Show-Me Institute.**

Opponents of the bill, led by the group that put the minimum wage law on the 2006 ballot, contend the change would overturn the will of voters who approved the law, with plainly stated ballot language noting the inflation adjustment, with 76 percent of the vote.

"If you work 40 hours a week, you should be able to expect a certain amount of buying power," said Laura Granich, director of Missouri Jobs with Justice.

Gas prices fluctuate, House Speaker Steve Tilley, R-Perryville, said, adding that he understands that pump prices can hurt low-paid workers.

But of the states that surround Missouri, only Illinois has a minimum wage that is higher than the federal minimum, he said. "We also have to make sure our state is competitive," said Tilley, who supports the measure.

The inflation adjustment, Tilley said, "puts us at a disadvantage for jobs."

Tilley added that he does not believe voters understood that they were voting for a wage that could rise with prices.

The federal minimum had not been raised for a decade when the vote took place, and voters were showing that they believed the minimum at the time, \$5.15 an hour, was too low, he said.

The 2006 ballot measure, known as Proposition B, set Missouri's minimum wage at \$6.50 an hour at a time.

It requires an annual adjustment — up or down — based on price levels, as measured by the federal government's index for urban wage earners.

It also requires that employers pay the federal minimum wage whenever that amount is higher than the Missouri minimum wage.

But it does not, as many people supporting the change seem to think, apply the adjustment to the federal minimum wage, Granich said.

The state minimum wage mandated by Proposition B peaked at \$7.05 an hour in January 2009; it fell 20 cents to \$6.85 an hour the following year and is currently \$6.95 an hour. Based on Congressional Budget Office price projections, Granich said, it would not exceed the federal minimum, and thus impose higher labor costs, until January 2015.

Higher prices hurt all consumers, she said, but it hurts low-wage workers the most.

"It just slowly eats away at their ability to make ends meet, paycheck to paycheck," she said. "It also eats away at the economy. When you give a dime to those workers, it goes right back into the economy and creates local jobs, more so than highly paid workers."

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# ST. LOUIS POST-DISPATCH

## From academics' view, reform of college athletics will never work

By Steve Weinberg • Special to the Post-Dispatch | Posted: Sunday, February 27, 2011  
12:00 am

**For 33 years, I taught classes at the University of Missouri's main campus in Columbia. Every year, I felt my indignation kick in as students, fellow faculty, administrators, staff, alumni and townspeople with no direct connection to MU seemed to show more concern about the football and basketball teams than about teaching and research.**

It turns out some folks have been feeling similar indignation since the 1850s, with the dawning of intercollegiate athletics. Ronald A. Smith, a professor of sports history at Pennsylvania State University, has documented the indignation and the failed attempts at reform in a book remarkable for its breadth and depth.

The book is part of a series called "Sports and Society" published by the University of Illinois Press, with headquarters in Urbana. A list of all the books forming the series is at the back of Smith's tome, and is impressive. There have been 50 titles so far, including a previous book by Smith about football at Harvard University during 1905.

For would-be reformers of college athletics such as myself, Smith's book is profoundly depressing. Even a future president of the United States, Woodrow Wilson — generally considered an intellectual — became an unabashed advocate of big-time sports at his university, Princeton, helping coach the football team. When Wilson ascended to the presidency of Princeton, he saw the out-of-control boosterism from a different perspective, and tried to institute measures that would have brought athletics and academics into better balance. He failed. Smith quotes Wilson as saying, "The sideshow has swallowed up the circus."

To understand what went wrong (or, a majority might argue, what did not go wrong), Smith examines the mania for college athletics from multiple perspectives: students, student-athletes on scholarship, faculty, coaches, athletic directors, university presidents, university governing boards, alumni, nonalumni fans of the teams, financial donors to universities, legislators, judges, journalists, outside study and advocacy groups, plus, later, the National Collegiate Athletic Association. Not so incidentally, the NCAA began its life during the first decade of the 20th century, primarily in response due to deaths and serious injuries on college football fields.

At first, reformers believed university presidents — often fervent academics with doctorates — would lead the way to sanity. Wrong. Smith has studied the papers of countless university

presidents, current and former. His conclusion: "Presidents are knowledgeable about the problems in athletics, but they are often the chief cheerleaders for their institution, and though they often offer high-sounding words about reform, their actions do not always coincide with their rhetoric."

For all its interesting, super-heated language, the book is scholarly to the extreme and relentlessly chronological. Smith opens with a rowing (crew) competition between Harvard and Yale universities in 1852, and builds from there.

Oh yes, getting back to academics, the stated primary purpose of colleges and universities: Smith says "Nearly always, a stated reason for reform (of athletics) has been to further academic integrity. Seldom has this been the primary accomplishment of reform."

How come? Here is Smith again: "It is difficult, if not impossible, to attempt to create athletic programs that are educationally sound and based on principles of amateurism when the historical model for well over a century is professional in many respects and generally financed commercially."

Reformers operate from other motives, too. On many campuses, big-time athletics damage morale of faculty and staff, who see stratospheric football and basketball coaches' salaries as everybody else swallows reductions. Athletic programs sometimes increase budget deficits rather than earn money for the campuses. Furthermore, students sometimes suffer serious injuries due to the brutality that comes along with the winning-at-all-costs attitudes.

So, I will continue my tiny protest by boycotting MU football and basketball games and occasionally speaking out. Many of my colleagues and friends will make fun of me, as they always have, and I will probably die without seeing even a bit of meaningful reform.

*Steve Weinberg is a book reviewer and author in Columbia, Mo.*

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### **‘Pay for Play: A History of Big-Time College Athletic Reform’**

By Ronald A. Smith

University of Illinois Press, 344 pages, \$30