MHA

100 YEARS OF HELPING HOSPITALS

1922-2022

A History of the Missouri Hospital Association by Tom Sebacher

Preface

It's not often that recent students receive opportunities to write books such as the one that lies before us. Although I have education and practice in historical writing, I will admit this book was a difficult one to write — the documents that were available sometimes had gaps that took people to fill in, and vice versa. Coordinating all these different narratives into a single whole that contains a history, not only of the Missouri Hospital Association and its members, but the whole health care system in general, was one that I realized would be much more difficult about halfway through the process. For this reason, I have several people for whom I am thankful. First, for the opportunity to write this book, I thank Mary Becker, who indulged me by allowing me to view a number of documents and internal memos and indeed gave me these opportunities in the first place. Her assistant, Jan Trachsel, has been very helpful as well, although my constant requests for more information and documents may have worn on her nerves. For their insights during interviews, I thank Charles Bowman, Marc Smith, Jerry Sill, Ken Kuebler, Dwight Fine and Herb Kuhn. Writing and narrative advice provided by Dave Dillon was also helpful in producing this single narrative of a hundred years of hospital and association history. Finally, for Brian McGeorge, for his design expertise in producing the final product.

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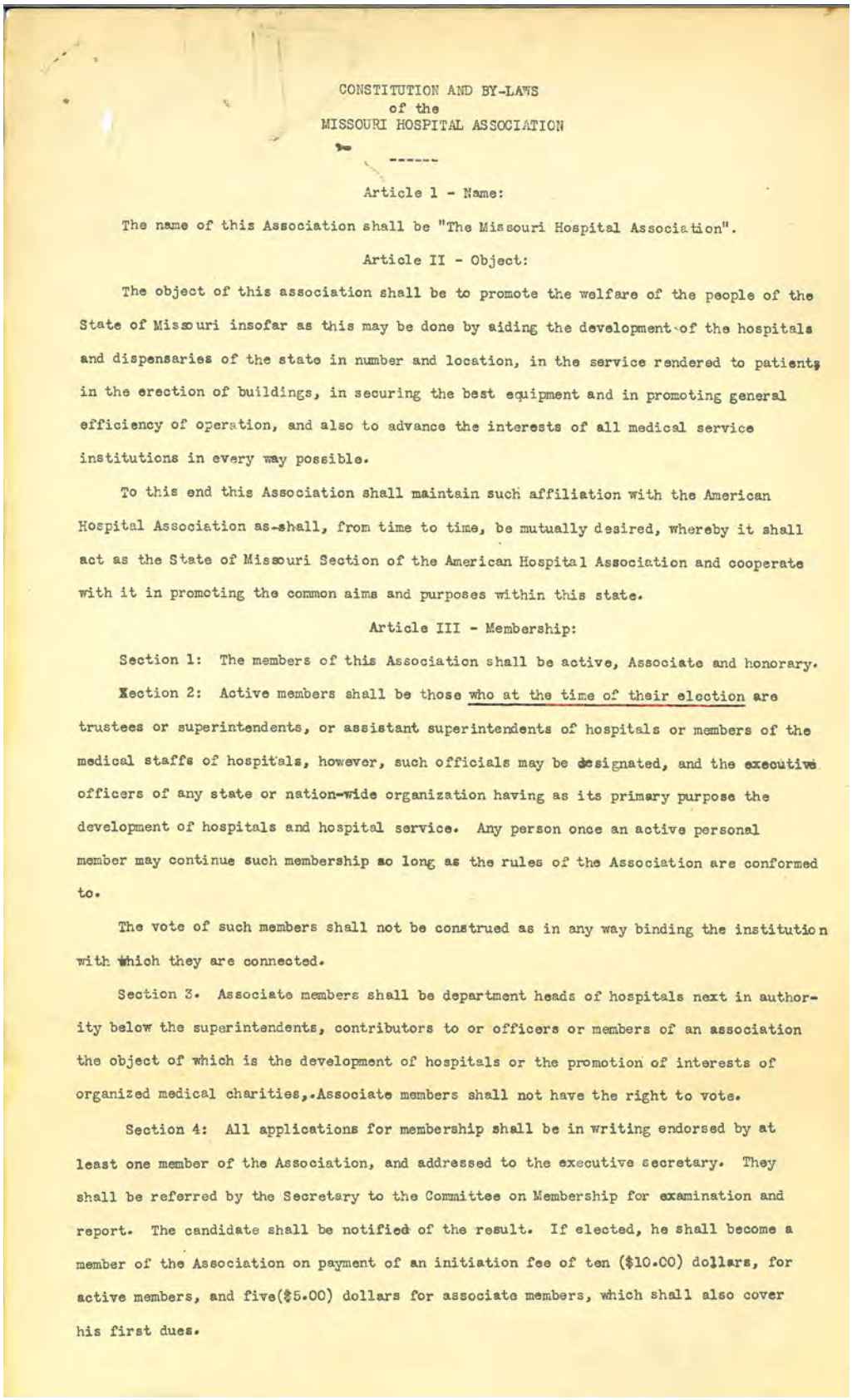


CONSTITUTION AND BY-LAWS
of the
MISSOURI HOSPITAL ASSOCIATION

Article 1 - Name:

The name of this Association shall be "The Missouri Hospital Association".

Article II - Object:

The object of this association shall be to promote the welfare of the people of the State of Missouri insofar as this may be done by aiding the development of the hospitals and dispensaries of the state in number and location, in the service rendered to patients in the erection of buildings, in securing the best equipment and in promoting general efficiency of operation, and also to advance the interests of all medical service institutions in every way possible.

To this end this Association shall maintain such affiliation with the American Hospital Association as shall, from time to time, be mutually desired, whereby it shall act as the State of Missouri Section of the American Hospital Association and cooperate with it in promoting the common aims and purposes within this state.

Article III - Membership:

Section 1: The members of this Association shall be active, Associate and honorary.

Section 2: Active members shall be those who at the time of their election are trustees or superintendents, or assistant superintendents of hospitals or members of the medical staffs of hospitals, however, such officials may be designated, and the executive officers of any state or nation-wide organization having as its primary purpose the development of hospitals and hospital service. Any person once an active personal member may continue such membership so long as the rules of the Association are conformed to.

The vote of such members shall not be construed as in any way binding the institution with which they are connected.

Section 3. Associate members shall be department heads of hospitals next in authority below the superintendents, contributors to or officers or members of an association the object of which is the development of hospitals or the promotion of interests of organized medical charities,.Associate members shall not have the right to vote.

Section 4: All applications for membership shall be in writing endorsed by at least one member of the Association, and addressed to the executive secretary. They shall be referred by the Secretary to the Committee on Membership for examination and report. The candidate shall be notified of the result. If elected, he shall become a member of the Association on payment of an initiation fee of ten ($10.00) dollars, for active members, and five($5.00) dollars for associate members, which shall also cover his first dues.

1922 Missouri Hospital Association constitution.

Section 5: Persons entitled to honor through public or private service in the hospital field may be nominated by the Membership Committee for election to Honorary Membership. A majority of favorable votes from the members present and voting shall constitute an election. Honorary members shall be exempt from dues and have all the privileges of active members except vote.

Article IV - Officers:

Section 1: The executive officers shall be a President, two Vice-Presidents and a treasurer elected annually by the Association; a board of trustees elected as provided in Section 2, and an Executive Secretary elected by the trustees.

Section 2: The board of trustees shall consist of the President of the Association, who shall be chairman of the board, the treasurer and five members of the Association. One member of the first board shall be elected for one year, two members for two years, and two members for three years. At each subsequent meeting of the Association trustees shall be elected for a period of three years to fill all existing vacancies on the board.

Article V - Vacancies:

Section 1: All vacancies existing in the executive offices between elections shall be filled by the trustees for a term of office ending at the next regular meeting of the Association.

Article VI - Amendments:

Section 1: The Constitution and By-Laws may be amended by the vote of not less than two-thirds of the members present and voting: provided that the proposed amendments were submitted in writing and read in full before a previous session.

1922 Missouri Hospital Association constitution, continued.

BY - L A W S

Article I - Meetings:

Section 1: The regular meetings of the Association shall be held at the places and on the dates fixed by the Association or by the trustees. The president and the Executive Secretary shall arrange the program.

Section II - Special meetings shall be called by the President, or in his absence by the Vice-President, upon the written petition of not less than ten members. The petition shall state the purpose of the meeting and no other business shall be transacted by this meeting. Not less than ten (10) days before the set time for any special meeting the executive secretary shall mail to all members a copy of the petition and the time and place set for the meeting.

Section 3: Ten voting members shall constitute a quorum.

Section 4: Roberts Rules of Order shall prevail.

Article II - Elections:

Section 1: All officers shall be elected by ballot unless otherwise provided.

Section 2: A majority of the votes cast shall constitute an election.

Article III - Duties of Officers:

Section 1: The president shall preside at the meetings of the Association and the board of trustees. He shall appoint all standing and special committees and be a member ex-officio of all standing and special committees.

Section 2: In the absence of the President the Vice-Presidents in the order of their rank, shall perform his duties.

Section 3: The executive secretary shall be a member of all standing and special committees. He shall keep all records in proper form and conduct the affairs of the Association under the guidance of the board of trustees, of which he is the executive officer. He shall make due report of his acts to the annual meeting.

Section 4: The treasurer shall have the custody of the funds of the Association and shall keep due and proper record thereof. He shall countersign all vouchers for the payment of indebtedness of the Association certified to be correct by the Executive Secretary.

Section 5: The board of trustees shall transact all business of the Association not otherwise provided for when the Association is not in session.

1922 Missouri Hospital Association constitution, continued.

Article IV - Committees:

Section 1: The President shall upon election, appoint the following standing committees: An Auditing Committee of three (3) members, a Membership Committee of three (3) members, a Committee on nomination of officers of three (3) members, a Legislative Committee of five (5) members and a Constitution and Rules Committee of three (3) members, designating the chairman of each.

Section 2: The Auditing Committee shall audit all accounts of the treasurer and the executive secretary, reporting the correctness thereof to the Association.

Section 3: The Committee on Nominations shall nominate to the Association, candidates for all elective officers. Corresponding nominations may also be made from the floor.

Section 4: The Membership Committee shall consider all applications for membership and express to the Executive Secretary either their approval or disapproval thereof.

Section 5: The Committee on Constitution and Rules shall receive, consider and report on all proposed amendments to the Constitution and By-Laws, and also on all proposed resolutions. No vote shall be taken on any amendment or resolution until the report of this committee thereon shall have been presented and read.

Section 6: The Committee on Legislation shall report at each annual meeting on national and state legislation of interest to hospitals.

Section 7: Special Committees for any particular purpose may at any time be appointed by the President. Their duties will be to serve the purpose designated.

Article V - Dues:

Section 1: The annual dues of active members shall be ten ($10.00) dollars; of associate members five ($5.00) dollars, which shall include membership dues in the American Hospital Association. Dues shall be paid to the Executive Secretary of the Association on or before each annual meeting of the Association.

Section 2: Any member delinquent in his dues more than two (2) years may be suspended from membership after due notice.

Section 3: Any delinquent may reinstate himself upon payment of all back and current dues.

Article VI - Proceedings:

Section 1: All papers read before the Association shall become the property of the Association and the trustees shall determine all publication thereof.

Article VII - Privilege of Floor:

Section 1: By vote the Association may extend the privileges of the floor to non-members.

1922 Missouri Hospital Association constitution, continued.

Article VIII - Discipline:

Section 1: All charges against members must be presented in written form and signed by at least three (3) members and shall be referred to a special committee which shall make written report with recommendations as to action.

Section 2: A copy of the charges shall be given to the alleged offender by the Executive Secretary of the Association.

Section 3: The Association shall have the right and authority to reprimand suspend and expel any member guilty of violation of any of the provisions of the Constitution and By-Laws of the Association after a full and fair investigation shall have been made.

Section 4: A four-fifths vote shall be necessary for expulsion.

Article IX - Order of Business:

Calling of the Association to order. Reading of minutes of the previous meeting. Announcements. Unfinished business. Reports of committees. New business. Presentation of papers and discussions.

Article X - Amendments to By-Laws:

No part of these By-Laws shall be suspended, altered, or changed, except as provided for by Article VI of the Constitution.

1922 Missouri Hospital Association constitution, continued.

Prologue

"The Missouri Hospital Association acknowledges that good health is a right of all Americans and not a privilege to be enjoyed only by the affluent and recognizes that the health of its individual citizens is the paramount consideration for the health of the state of Missouri.

"The Missouri Hospital Association, therefore, pledges its collective efforts and the efforts of its individual members toward providing the best institutional care; cooperation in all phases of prevention, treatment and care of disease, injury and infirmity; and continuing emphasis on technological advances and operating efficiencies to make the fullest extent of care within the economic reach of all."

These words were written as the preamble to the association's constitution that was adopted in 1966, but it isn't merely a snapshot, a single document reflecting the opinions of one specific time. As the history of MHA has gone on, from its founding in 1922 to the present day, the organization has changed as health care and the roles of hospitals have. However, as medicine and hospitals have changed, it maintained a single principle: healing and care for communities. This same philosophy has been present in all the years that MHA has advocated for its members. Regardless of the decisions made and how one views them in the future, they were made for the good of hospitals to serve the people.

These values are unquestionable, but the methods of achieving care for communities have changed significantly since the founding of MHA to the ratification of this constitution, and still to this day. Tracing the history of this organization is equivalent to tracing the history of how people thought of health care, and how they worked together to achieve a common goal. Whether it's advocating for years for the expansion of the Medicaid program from 2010 to 2020, or helping to distribute funds from the Hill-Burton Act of 1946, the focus has always been on how best to expand health care with the conditions on the ground. When resources were spread thin for individual hospitals, the association coordinated between them to improve outcomes overall; when hospitals struggled during nursing shortages, MHA helped organize and accredit more schools for nursing. When the COVID-19 pandemic struck in 2020, the organization adopted strategic plans for the worst-case scenario, helping the state distribute resources to the places where they were needed most.

Regardless of what the struggle was, the association has been the point of the spear in finding a solution. It has organized to implement changes to the health care system ahead of federal and state intervention, driving its members to closer cooperation and group innovation. The whole organization has been geared toward ensuring that hospitals in the state operate in an environment that allows them to run at the maximum level of efficiency, a goal that improves not only the lot of the health systems, but the communities they serve. A hospital is a community institution; it is intimately tied to the people who depend on its professional staff and quality care. An association of hospitals is an institution that serves this specific community of organizations and hospitals, the institution that hospitals can rely upon in their times of need.

The Early Years
(1922–1957)

On February 17, 1922, 50 delegates came together in the Statler Hotel in St. Louis, all representatives of various hospitals in the state, to organize a new chapter of the American Hospital Association (AHA): the Missouri Hospital Association. An organization dedicated to coordinating between several different health systems in Missouri, MHA had 40 founding members that have now grown to more than 140. Under a number of talented presidents and executive officers, the organization has shifted its priorities as national and state governments intervened in the structure of American health care, but its goal has remained the same: to provide consistent, affordable health care to the people of Missouri.

The founding meeting of the association had been in the works for nearly a month before the 50 delegates met in the Statler Hotel. Three hospital administrators tasked with planning the organization had announced the meeting the month before. According to the *St. Louis Star and Times*, these three planners were Dr. Rolla Henry of St. Louis City Hospital, Dr. Louise Ament of Lutheran Hospital and Albert C. Stowell of Kansas City. It is unclear exactly what their roles were during the convention the following month, but Dr. Ament would later be elected as MHA's first treasurer.

The times between 1922 and the establishment of permanent offices in 1957 were turbulent, not only for MHA, but for the whole country. The Great Depression, World War II, the Red Scare and the beginnings of the Cold War brought forward challenges that would have to be taken in stride. These same challenges made organizing sporadic and difficult during this part of its existence. Information on the actual activities of MHA in its earliest years is scarce. However, in rough outline, we have some basic information gleaned from newsletters such as the *Monthly Bulletin* and newspapers such as the

St. Louis Post-Dispatch. The organization's founding documents, its constitution and articles of incorporation also allow us to look into the minds of the people who met in that room in the Statler Hotel a century ago and give us a look into how the organization has changed since.

The organization's first president was Louis H. Burlingham, the superintendent for Barnes Hospital in St. Louis, who headed the association as an affiliate of AHA. Its first action as an association was to tour the St. Louis Children's Hospital and the City Hospital, where it would meet to discuss matters of the organization, including the bylaws. During its earlier days, this was a part-time position; the association didn't have the budget to spend on a full-time staff. When the treasurer collected dues for the first time in 1922, the resulting $190 would be equal to just over $3,000 in 2021. This meant that most administrators for the association continued their positions at the hospitals they represented. Early meetings, including those in the late 1920s and early 1930s, were primarily concerned with increasing attendance so that the association would be able to get a complete picture of the problems each member institution was experiencing. Regardless of resources, the association sought to inform the public on health issues; in 1927, it warned workers of the Missouri Pacific Railway and inhabitants of the Missouri and Mississippi river valleys of a typhoid epidemic, recommending that citizens get inoculated against the disease.

In 1936, only 20 members were present at the annual meeting; the group's first 15 years were rocky, with problems ranging from the loss of funds in the 1929 Wall Street crash to meeting attendance problems. Following a cascade of financial failures caused by the collapse of the markets, the Chippewa Bank, where the association stored its funds, went under in 1929. Because of the limited insurance offered for deposits at the time, MHA lost everything it had deposited there. By 1938, the group had gotten back up onto its feet, finding a unifying issue to bring the health care community in the state closer together: a comprehensive medical program to cover health care costs for the indigent (those who have insufficient resources to pay for medical care). During this year, the organization advocated for group hospital coverage, which was a prepaid plan subsidized by the state that would help pay for those who were unable to pay. MHA representatives, in coordination with the Missouri State Medical Association (MSMA), drew up a plan for a Health Security Administration to ensure that all Missourians would be able to receive quality health care. Consisting of a tripartite arrangement of group hospitalization coverage, post-payment plans and assessment of indigent status, it ensured that those who were unable to pay under normal circumstances would be covered. With this goal in mind, MHA also advocated for workplace insurance

associations, such as the Group Hospital Service, a group hospitalization plan founded by the St. Louis Medical Society in 1935.

Even with these limitations, the organization was active in investigating a number of issues that would allow it to develop skills and strategies for the future. The organization held annual meetings and fought for the rights of its constituent hospitals. Much of this time was spent in developing relationships between hospital leaders and members of the legislature — an effort that bore fruit later as MHA developed its permanent staff. The legacy of its legislative and professional education programs is visible in the programs it sponsored later, involving themselves with the expansion of nursing certifications and increasing the capacities of nursing schools. In addition, the organization lobbied for the licensure of licensed practical nurses (LPNs) to expand the potential for hospitals and practices to care for the ill and injured.

Few records allow a glimpse of the organization's activities during the period from 1922 to 1938. But the Missouri group was an affiliate of AHA, which participated in a number of national legislative issues. Much of MHA's activities likely were in the form of educational seminars and meetings to discuss collective issues between Missouri's hospitals. The earliest available newsletters discuss the use of constructive criticism and feature discussions between hospitals on how to solve "seemingly insurmountable problems." These problems could be solved with collective action, cooperation and planning of strategic resources. There were several changes in leadership, notably the election of Florence King in 1932 and her subsequent stepping down as president in 1938, but overall, it is difficult to get a complete list of presidents or officers of the association during this time period.

A census of health care institutions in the United States in 1932 indicated that most people visited state hospitals rather than private ones. The shift from public hospitals to private hospitals was a gradual one; private hospitals typically started out as charities rather than profitable enterprises. Most hospitals around this time were founded by voluntary or religious organizations, many associated with the Sisters of St. Mary or the Sisters of Mercy. Many were primarily supported by donations and significant contributions from wealthy sponsors rather than billed medical procedures. During the 1952 state hospital association convention, speakers discussed a sixfold increase to charitable funds provided by major corporations, including Ford and General Motors, to be spent in the public welfare. Many of the association's early presidents were members of other community organizations. Dr. Frank Bradley, one of its presidents in the 1940s, served as president of the American College of Hospital Administrators, as a member of AHA's committee for Hospital Planning and Plant Operations, as council member of the St. Louis Medical

Society, and in a host of other positions with national and local health organizations. Hospital administrators' involvement in the health of their communities reinforced the fact that they were becoming centers for community health.

With strengthening ties to the community, hospitals across the nation took up issues of importance to their constituents. The Missouri and Midwest Hospital Associations held a joint convention in 1932, where they discussed the importance of federal aid in caring for the injured of the First World War. This conflict was one of the most brutal periods of the 20th century. With both sides developing and using chemical weapons, as well as other tactics designed to cause maximum trauma, the war left anywhere from the hundreds of thousands to the millions with permanent injuries. While the government committed to care for these sufferers of chronic injuries, they had limited space or expertise to do so; many ended up in local hospitals rather than the specialized veterans' hospitals.

Beginning in 1938, MHA began publishing the *Monthly Bulletin* — a newsletter that carried the latest updates on health laws, AHA resolutions and changes to the field of health care as a whole. It acknowledged that the organization was busy with "the establishment of institutional membership" among Missouri's hospitals. MHA had grown its roots among the local hospitals, despite numerous setbacks, illustrated by its establishment of a permanent office in 1957. Other notable developments of the time were the establishment of Blue Cross Associations in St. Louis and Kansas City, the immediate precursors to the modern Blue Cross Blue Shield networks. These organizations helped finance the treatment of individuals, coming to prominence during and immediately after the Second World War. In 1946, the U.S. Congress passed the Hill-Burton Act, expanding funding for indigent care, or care for those who were unable to pay on their own. These two developments set the stage for further expansions of medical coverage during the 20th century.

While MHA helped establish the Blue Cross-Blue Shield associations, its interactions with them were complex. While both supported each other when it was of mutual interest, the interests of Blue Cross groups often conflicted with those of hospitals when it came to coverage of hospital expenses and negotiating the prices of procedures to mitigate costs to patients. The dispute arose over the role of the Blue Shield group in handling medical billing, rather than the Blue Cross with whom the contracts were negotiated. The former was supported and sponsored by MHA while the latter was sponsored by MSMA; the controversy was over the identity of the doctors within the hospitals. Blue Cross had handled payment for hospital services, while Blue Shield handled payment to physicians or patients directly for medical services given in hospitals. At the same time, MHA

sponsored efforts to establish and later extend coverage through group hospitalization plans, such as those sponsored by Group Hospital Service, Inc. The nonprofit insurance company had covered over 85,000 people by 1939, with minimal conflicts with providers of commercial health insurance. By 1948, Blue Cross paid over $20 million to hospitals on behalf of nearly 400,000 members, all the while with support from MHA.

Health planning was a significant priority for the association throughout this time period; their priorities in 1938 included a survey to plan further expansion of state hospitals, a project in which it partnered with the state medical association. Hospital surveys in 1938 focused upon the cost of treating the indigent in the state, as well as the potential benefits of group hospitalization programs such as Blue Cross or Blue Shield. Partnerships with professional organizations had two overarching goals: the expansion of care through institutional growth and ensuring the quality of care through setting standards for the facilities already operating. MSMA and MHA cooperatively formed a plan that would allow for a state agency for medical and dental service, which would aid physicians and institutions in aligning their costs to the patient's abilities to pay. All the while, administrator Frank Bradley explained, "There [was] a revolution going on in the hospital world … a complete transformation, particularly in the business functions of the hospital." To sustain operations among increasing costs, the hospital community needed a new system of costing, billing and reimbursement. The issue did not end with the establishment of the Hill-Burton Act in 1946, as the association's convention in 1951 focused on compensation for the treatment of the medically indigent. While the government program compensated hospitals for "charity care," or indigent care, it did not cover the full costs of their treatment.

In 1944, the Missouri Farm Bureau and MHA began their complete survey of health care institutions, raising $26,000 for the purpose; one of its primary conclusions was that "rural Missouri ha[d] a tremendous lack of hospital beds," given that Springfield, Poplar Bluff and Kirksville only had roughly one bed per 1,000 people. The state's southeastern portion had a hospital bed-to-population ratio of 0.7 beds per 1,000, less still than the other rural areas. After the passage of Hill-Burton, this indicated the state should spend more of the expansion money on rural hospitals or health centers, a move supported by the Missouri Farm Bureau, MSMA and other concerned health care groups.

In 1945, MHA's influence, as well as that of other groups, helped shape the state's new Department of Public Health and Welfare. After the state adopted a new constitution in 1945, provisions called for the establishment of a new state department for public health, an effort in which MHA took an active role. When the state legislature met to decide exactly how the department would take shape, MHA, in partnership with 15

other organizations, testified before the Senate to ensure that the organization would be an apolitical body. This partnership, known as the Citizens' Committee for Organization of a Department of Public Health and Welfare, represented a broad coalition of hospital, professional, women's, racial and veterans' groups. The Citizens' Committee proposed an amendment that gave the department a significant amount of independence from the governor and legislature, a move to which several legislators objected.

MHA policies were discussed at several levels, most notably on the state and local levels, but also in regard to the problems facing hospitals nationally. AHA met in St. Louis in 1935, holding its six-day convention to discuss matters important to all hospitals. Meanwhile, the Children's Hospital Association and Protestant Hospital Association held meetings at the same time in the city. MHA, although less active during the time between 1929 and 1938, undoubtedly had members attend these conventions to discuss prominent issues in the state and the nation. To this purpose, the association set up self-reviews to evaluate quality of care, an issue in which the national and state associations of hospitals were becoming intimately involved. Throughout this time period, MHA sponsored planning of hospital expansions, with its convention in 1954 arguing that "large sums are wasted by bad planning," which it found the states frequently engaged in. Other problems of planning included inabilities to hire sufficient staffing to manage increased numbers of beds; in 1948, the association partnered with the Missouri Board of Education, city hospitals of St. Louis and the Council on Community Nursing to increase access to nursing education.

After the passage of the Hill-Burton Act in 1946, with increased availability of federal funds for the construction of hospitals, the association began coordinating between various communities that were interested in establishing new hospitals under the law. In 1946, the Oak Ridge Clubs contacted MHA with a plan to establish a new public hospital in Warren County, which had no local hospital at this time. Later, Warren County would attempt to establish a medical center using funds raised with MHA's help, lobbying for Hill-Burton funds. In 1944, the organization already acknowledged a dearth of hospital institutions throughout the state. Frank Bradley noted that the vast majority of general hospitals were located either in St. Louis or Kansas City, "leaving 70 counties devoid of hospital facilities."

Other key pieces of legislation ensured the smooth operation of hospitals to provide consistent care; one such bill was the King-Thompson Law. This law prevented union strikes in the utilities industries, which could disrupt lifesaving treatments and surgeries in affected hospitals, which would subsequently be unable to operate fully. Testifying alongside representatives of the St. Louis Chamber of Commerce and the

wife of a farmer, Thomas Fox — the association's representative — argued successfully in committee that the bill would be in the interests of public health in 1957. After ordering state hospital surveys in 1946–47, Governor Philip Donnelly called for an expansion and reworking of state mental health services, a problem that persisted into the 1950s. During social club meetings and informational sessions, MHA representatives would advocate for the expansion of mental health care and psychiatric services, one such involving association President Harry Panhorst speaking before the Zonta Club of St. Louis County in 1957. The association worked to inform the public at both of these less formal gatherings, as well as through its conventions and board meetings, all of which were open to the public. Senator Albert M. Spradling often spoke at the MHA conventions in the early 1950s to advocate for the expansion of psychiatric hospitals and nursing homes.

For the purpose of efficiency, the association established its four-district plan in 1938, which divided the various hospitals into "four compact, cooperative units" to facilitate the ability of the districts to collect information and lobby more effectively for the hospitals that comprised them. With this development, and the cooperation of regional hospital organizations in St. Louis and Kansas City, the organization presaged its later organizational structure, with divisions each having somewhat different priorities. While this is the case, MHA did not fracture along regional lines due to these differing interests but remained stronger with cooperation. Cooperation was handled among regional lines, as well as local and national lines; MHA executive officers frequently attended the gatherings of the Midwest Hospital Association, which represented hospitals from Missouri, Oklahoma and Kansas. The regional body worked with Missouri hospitals and the state associations on nursing shortages and manpower training, discussing the importance of state nursing boards and licensure at several of its annual conventions. National representatives were frequent attendees of the Missouri organization's annual conventions, bringing problems from other states to MHA's attention, so that it might prevent them from taking hold. One example was the wrangling over the definition of health services in Iowa, where doctors had successfully lodged a legal action against hospitals to take responsibility for anesthesiology. This led Dr. Bradley, the president of AHA, to urge the state body to increase communication with doctors' groups and lobby for more specific definition of medical services.

The development of a medical corps was an important aspect of the war effort in the U.S., as numerous doctors, nurses and support personnel joined the military to care for the ill and wounded. Even before the war, the health care community was feeling the potential for severe disruptions. At the 1941 convention, the head of the Missouri

Pacific Hospital Association (an interstate organization originally founded in St. Louis for Missouri Pacific Hospitals) noted that the state's hospitals "must pay fair wages" to attract skilled medical personnel, acknowledging that it was difficult to do so when they still operated essentially as charity institutions. Florence King, the association's president that year, noted two months before the world war's outbreak that "needs for defense … made heavy inroads on [Missouri hospitals'] nursing and other personnel." These shortages compounded with a demand for medical equipment that had outpaced the supply of that equipment, leading to increased prices. King was optimistic in the face of these adversities, asserting that "hospitals will doubtless benefit in many respects from the severe tests placed upon them." The problem would only become more dire as the war effort progressed, prompting wartime rationing that strained hospital resources on the home front. While these occurred, the association held emergency meetings to discuss rationing and recruitment of essential personnel in 1943. With advancing shortages, AHA founded the Wartime Services Bureau to aid in national distribution of staff and resources.

At the same time, employers on the home front began to offer health insurance and benefits to entice workers to choose them; the industrial and service labor markets were also strained by the war. Private health insurance plans, such as the Blue Cross Associations, began to offer services along these lines, setting the foundations for the future of health care financing and insurance. Amid calls for a national health insurance, some public health advocates (notably union leaders) favored the socialized medicine platform implemented in the United Kingdom, to be covered by a 1.5% tax on employer and employee, respectively. However, there was not sufficient evidence that it would decrease the margins from the voluntary health insurances already in place, of which Blue Cross operated with around the same overhead of the British system.

As these developments moved forward, MHA sponsored innovation on the insurance front, continuing its support for the Blue Cross Associations in St. Louis and Kansas City, which would later become important local insurance companies in the second half of the 20th century. It pioneered cooperative efforts to improve standards of care through increased funding and inquiries into hospital efforts to care for the families of servicemembers. The organization urged that hospital administrators express their problems to legislators and local officials, as well as to the community at large. Publicly acknowledging the problems of Missouri hospitals was the first step to solving the problems they faced, a strategy employed by then-President Reverend Paul R. Zwilling. To this end, Zwilling encouraged hospital administrators to attend AHA and MHA meetings, as other MHA presidents later would. During its 1948 convention, nearly

10 years after Zwilling urged hospitals to inform the public, the state association held a hospital clinic to educate hospital administrators on public relations. This allowed hospitals to understand how the public viewed them and marked an important step in their transition from more charitable to more businesslike institutions. While it should not be overstated, this trend has continued throughout the organization's existence, and to an extent, it remains prescient.

During the war, MHA decided to perform a nonmandatory survey of state hospitals to advocate for federal funding. The association's then-president, F. M. Bradley, argued that federal funds to expand health care providers would only be forthcoming if they could report the respective capacities of each hospital. Bradley successfully predicted what would happen in 1946 when the Hill-Burton Act was passed, funding indigent care particularly in rural hospitals, which received less revenue. During and immediately after the war, MHA meetings often focused upon new techniques developed due to combat innovation, including blood and plasma transfusions spearheaded by a Washington University physician who received the Bronze Star. The state was at the forefront of several health crises, including a polio outbreak in 1948 and numerous tuberculosis outbreaks. Members of the association advised the Missouri Health Division on actions that the state might take to prevent polio from overwhelming the three hospitals that could treat infantile paralysis patients.

Advocacy for the indigent and the Hill-Burton Act would allow hospitals with more limited resources to stay afloat even if they were to minister to a large number of people who would be unable to pay — this would mean both stronger hospitals in rural areas and increased access to health care. Soon after, it was promising that the Missouri Farm Bureau offered aid to establish more rural hospitals to be underwritten by pooling farmers' funds. They revealed this during MHA's second wartime meeting in 1944, where the Farm Bureau representative stated that they would support the building of 30-60 bed hospitals in outlying areas. Around the same time, AHA founded the Wartime Services Bureau in Washington D. C., to aid in the distribution of rations and in other essential health care services tied to the Second World War. Other war issues included the Emergency Maternal and Infant Care program, a federal program that subsidized the care of military wives. During 1944, a controversy arose where a woman accused a St. Louis hospital of denying her care. A state-appointed investigative committee included Irene McCabe who served as MHA's secretary at the time. Reporting in November of 1944, the committee came to the conclusion that St. Louis area hospitals had worked with physicians to ensure that women were not denied "reservation" (admission) at institutions under the program.

The organization often held talks centering around care of indigents and the role of charity care in the hospital community. Eying recent developments in the U.K., MHA addressed the establishment of a fully public health insurance service at its 1944 convention, concluding that such a move might not be advisable in the U.S. given the professional and economic differences in health care in the two countries. At the 1954 convention, speakers argued that it would make less sense to establish new hospitals for the care of those who couldn't pay, but rather that indigent care could easily be taken care of at existing hospitals. This would prevent unnecessarily costly expansions of services, bringing down potential costs to both hospitals and the state. Furthermore, the association brought attention to indigent care in 1951, arguing that more funds should be available to support indigent care on the state level. While the care of the indigent was expanded by federal action under the Hill-Burton Act in 1946, the existing payment and price infrastructure were still insufficient to maintain adequate standards of care. To ensure that funds went to the areas that needed them most, MHA helped conduct a survey of institutions done by the state Division of Health, which would assess the needs of the state's hospitals. Care for those deemed senile or incompetent was a major issue at the time, particularly during the 1950s when the state investigated conditions of overcrowding and considered expanding funding for the state hospitals.

A lesser-known struggle of the state's health care institutions has been the tensions between osteopaths and medicinal doctors. During the 1951 MHA convention, Melvin Casberg, the Dean of the St. Louis University Medical School, urged the two groups to become a united whole, urging medical doctors not to consider the osteopaths as "quacks." He noted that "the merger will happen eventually, so why not now," arguing in favor of a unified board of licensing and equivalence of degrees in osteopathy and medicine. The two would be forced to confront their differences due to a Missouri Supreme Court decision in 1953, where the court upheld a ruling that hospitals could not discriminate in employment against osteopathic doctors (D.O.s). A medical field that had strong roots in Missouri due to the work of A. T. Still, D.O.s were originally excluded due to the differences in licensing requirements of medical doctors (M.D.s). They were organized under different organizations from M.D.s and were largely excluded from organizations affiliated with MSMA (the organization founded for medical doctors). The state's ruling and the employment of osteopaths at Missouri's hospitals resulted in 27 institutions being expelled from the American Medical Association (AMA) and AHA. While they maintained their memberships in the Missouri association, they were hampered in their interactions with these national bodies, leading the association to voice its opposition to the practice of excluding osteopaths, which administrators

argued would hurt patients. To this day, the split between osteopathy and traditional medicine has not been fully mended; both groups still maintain their own professional organizations despite ever-decreasing differences in training.

Some medical resources were involved in the war effort to help mitigate the potential threat of the use of chemical and biological weapons. Even after the war ended, the Department of Defense sponsored programs to investigate the potential threats of weapons of mass destruction on public health and how to counter these types of warfare. The U.S. and Union of Soviet Socialist Republics (USSR) created large stockpiles of chemical weapons, but these were never used. The expansion of health services under the Hill-Burton Act would allow for the establishment of more hospitals and an increased number of beds for hospitals already built, thus allowing for greater wartime capacity in the event of a chemical or biological attack. This helped justify expansion of the hospital care system in general, and stimulated MHA's campaign to educate more nurses across the state. Speaking on the shortage of nurses at the 1956 convention, the assistant surgeon general explained federal aid programs for nurse training, but also advocated for increased private donations and support of education. In this way, the mobilization of hospital personnel after the war occasionally reflected war-time trends. Missouri hospitals and their benefactors were mobilizing for what would become a constant struggle: ensuring skilled staff could care for patients.

In the immediate aftermath of the war, the U.S. confronted the possibility of a new struggle with the USSR. After the end of the Second World War, hospitals experienced significant shortages in staffing and resources that had not improved despite the allied victory in 1945. Administrators speaking at a meeting of the St. Louis County Medical Society in 1946, including MHA President Harry Mohler, recommended that hospitals make a concerted effort to decrease hospital stays, establishing a system of triage to determine the urgency of each patient's ailments. This was not the only problem in the postwar health effort; as tensions built in the late 1940s and early '50s, concerns for a new war effort thrust other issues of defense and national security to the forefront. At MHA's 1950 convention, a representative of the Medical Field Service of the armed forces argued that hospitals ought to recognize "the fact that care of casualties will be the first and biggest problem in case of atomic attack." The USSR had conducted its first nuclear test in 1949 and began the arms race with the U.S. as both countries greatly expanded their nuclear stockpiles.

Near the end of this era, concerns about quality of care made increased self-regulation and state regulation major concerns for MHA. In 1957, the state increased requirements for the licensing of nursing homes, mostly increasing the fire safety

standards for institutions, which was prompted by a fire in February of 1956 that killed 72 patients and staff. The association's role included managing the care of those who left institutions due to necessary upgrades to safety and advocating for increased funding to enact these safety upgrades. A further demonstration of the organization's influence during this time was the governor's appointment of one of its officers to the advisory council on nursing homes under the new licensing law. Association meetings frequently centered around new health regulations, with hospital administrators often asking questions and gathering information on how changes in state policy would influence their operations. Public health officials appointed by the state were frequent guests at MHA's annual conventions, especially from 1938 to 1956. The state furthermore sought the organization's aid in evaluating the fire safety systems of hospitals, and in response, MHA helped draft legislation to ensure that "thorough, adequate inspection … be provided" to prevent fires such as the one that ravaged St. Anthony's Hospital in Effingham, Illinois, in 1949 where 76 people died.

To that end, the association addressed a plea to the state legislature, authoring a bill to license hospitals in 1949 and create a public health division qualified to do so. To ensure that hospitals maintained a particular standard of care and safety, the organization favored a Committee on Hospital Standards, which was appointed by the governor. The hospitals' proposal also sought to give the state committee the authority to inspect institutions to ensure that the facilities were safe and that the patients had adequate access to nutritional food. The law passed, and the association subsequently sponsored meetings between hospital administrators and the director of the Division of Health to explain the new requirements. Concerns surrounding housing and safety were nothing new; MHA held educational meetings detailing techniques for evaluating housing and hygiene practices in the medical industry during its 1947 convention. Support for these state regulations were not universal and at times led to dissension between the state's inspectors and hospitals, setting the stage for future challenges, but the regulations did have a positive effect on health care quality. In 1949, the Department of Public Health fired the leader of its section of local health and hospital administration, a move that the association viewed as ill-advised due to the potential resignation of other well-respected employees. Administrators worried that the department was putting its political purpose above its purpose to ensure quality, accessible health care.

Standards of hospital care were the focus of the 1955 MHA convention, where the speakers argued that hospitals should voluntarily be invested in ensuring standards of care, rather than relying on state accreditation. Just the previous year, MHA had discussed the care of chronically ill patients in the state; demographic transitions from

a younger population to a more elderly one, as well as from a highly rural to an urbanized society, made it more difficult for the families to care for the elderly. The association committed to creating more robust rehabilitation programs and diversion of patients into long-term care facilities rather than acute care institutions. Hospitals and nursing homes that were turned down by The Joint Commission on Hospital Accreditation were urged to move above and beyond the existing statutes, not only for their own sake, but for the sake of their communities. This would prevent hospitals from encountering problems with state regulatory boards and ensure they remained open to help their communities.

Closer to the end of this time period, the hospital association began to address key problems of hospital administration that would only expand as time advanced. At the 1956 convention, speakers included representatives of the U.S. Public Health Service, AHA and state Division of Health. The following year, the state would enact a new hospital licensing law that was described by the state health spokesperson. Following this, the other speakers focused on nursing education, cost models for hospital services and third-party payment structures. By 1953, the association's conventions began including accounting and business classes, sponsoring additional educational events on management of funds and costs. In addition, MHA began investigating conditions and expansion of mental health services with the help of state Senator Spradling. With these future problems looming, the organization entered a new period of its history, and in 1957 decided to establish a permanent office and staff, managed from Jefferson City.

During the period from 1922 to 1957, MHA maintained its primary focus on the expansion of health services in the state. Secondarily, the distribution of resources and manpower during the war meant that more intense cooperation among hospitals and government bodies would occur. The nursing shortages Florence King noted before the war persisted after it ended; with expansions of the hospital service, the next step would be finding staff to manage that expansion. From its founding in 1922 to its expansion in 1957, MHA served the interests of hospitals and advocated on their behalf to obtain equipment and financial resources. It played an integral part in expanding health care and establishing government offices to regulate hospitals and health care institutions, balancing its strategies with the state's efforts to standardize care. State intervention would only increase as the institutions became more sophisticated and technologically advanced, a consequence of their integration into public life. Public demands for increased hospital care meant increased state attempts to expand and regulate hospital care.

MHA built partnerships with state, local and regional bodies to strengthen its hand, bringing itself into cooperation with Blue Cross and Blue Shield, as well as MSMA, Missouri Farm Bureau, AHA and the Midwest Hospital Association. Partnerships

with these and other commercial groups, such as the St. Louis Chamber of Commerce, would enable it to develop working relationships on issues of hospital and public health interest to the state and its citizens. Some of these partnerships have continued through the 20th century and into the 21st, particularly those with the Missouri Chamber of Commerce and Industry, Missouri Farm Bureau, and a number of other groups with whom MHA has recently collaborated on a variety of other public health issues. It has coordinated efforts with business schools and organizations, such as the Association of Medical Records Librarians, to ensure that staff of the hospital group and its constituent facilities have had adequate training as well. Increased educational requirements and new specializations in physicians' staffing has required increased education for administrators. This 35-year period saw the association's staff become increasingly specialized and more highly trained. Although administrators often had medical degrees, they now needed knowledge of accounting and budgeting, as well as training in public health planning, all of which were provided by MHA.

Building the Foundations
(1957–1985)

With these new developments and the expanding role of hospitals in the country, MHA made the move to establish permanent offices in 1957. Blue Cross organizations in St. Louis and Kansas City helped subsidize its initial operating costs, allowing members to overhaul the dues structure, collecting roughly $36,000 by 1960. Its income in the organization's first year of permanent operation was around $14,000, indicating its increased dues and streamlined structure was successful in making the organization at least somewhat self-sufficient. These increased resources would allow MHA to build a network of different support agencies to help promote a health agenda that benefited hospitals and the public at large. By 1967, the organization reported on-hand cash of over $16,000 and assets of over $70,000. Disputes arose between the association and Blue Cross, with whom MHA negotiated on behalf of St. Louis hospitals.

These policies ranged from increased educational activities, sponsorship of the Center for Health Careers and funding of informational campaigns, to the testimony of the officers of MHA before state and national committees of legislators considering changes in health care regulation and law. Major developments were underway, beginning with the 1962 Manpower Development and Training Act, the creation of the Medicare Program under the Social Security Act of 1965, then the creation of the Medicaid program of Missouri in 1968. Furthermore, the development of emergency services and increased technological advancement would increase the necessity for cooperation between health systems and the state government. In 1975, AHA helped establish a national communications system between hospitals, known as the Communications Network System, which served as a precursor to later attempts to coordinate between hospitals and emergency departments (EDs).

In 1957, the organization hired its first full-time executive officer and president, Ted O. Lloyd, who began his medical career in the military service. He began his health career in Higginsville where the state had set up a medical training school, but he later "found himself involved in plans for the … state hospital and school" there. The St. Louis State Hospital for the aged and intellectually disabled later hired him as their business director, and in 1950, the Phelps County Hospital — the first hospital in Missouri built with funds from the Hill-Burton Act — hired him as their first administrator. A local news article describing Lloyd's career noted that he was a "people person" and that "the word 'people' crops up in almost every comment the native of Belle makes." When he retired in 1974, Lloyd had headed the organization for 17 years, noting that his proudest achievement was in the field of nursing. He told the Jefferson City *Sunday News and Tribune*: "One of the Missouri Hospital Association's most significant achievements … has resulted from our group fostering the two-year degree program for nurses in community colleges and helping establish standards for LPNs. These actions have supplied rural and metropolitan hospitals alike with the trained people needed in increasing numbers today to provide health care for more people than ever throughout the state." This pilot program of the association included training courses and partnerships with schools to provide profession-specific trainings for LPNs, a group only recently integrated into the hospital workforce.

In its efforts to expand access to education for LPNs, the association partnered with the National Association for Practical Nurse Education to sponsor educational seminars in St. Louis. Standards of nursing improved during Lloyd's time as chief executive, partially due to MHA's partnerships with a broad range of professional and government-sponsored organizations designed to improve the quality of health care. Increased numbers of LPNs could also take strain off registered nurses and physicians who were already understaffed.

By 1965, MHA received dues of $52,000. Its campaigns to increase funding bore fruit in several partnerships that enabled it to continue its mission of education. It sponsored and funded institutes for keeping medical records, efforts that marked its commitment to bringing records together to improve health outcomes. During the 1960s, the U.S. government became worried that there would not be enough strategic or support personnel in the event of a future war, and in response passed the Manpower Development and Training Act in 1962. The goal was simple: Provide financial incentives to encourage people to enter health care and other understaffed industries valuable to the national well-being. It was around this time that MHA adopted the constitution that emphasized its commitment to Missouri's health and the health of its individual citizens. The association acted to expand cooperative action and collective purchase of equipment as well, instituting a program to purchase a shared computer for data

processing between several hospitals. During this period, the organization also acted as a negotiator between hospitals in the state and Blue Cross to resolve a dispute in reimbursement for hospital services under the insurance program.

Conflicts between the formerly MHA-sponsored insurance program and the association's members were increasingly frequent as the two began to drift apart during the late 1960s and early '70s. MHA engaged in a period of intense negotiations between Blue Cross and member hospitals during 1974 and 1975, negotiating prices with the organization in such a way as to ensure minimum costs to consumers with the maximum potential coverage. Meanwhile, the organization warned regional Blue Cross Associations to avoid mobilizing public opinion against them. This came after the Chicago Blue Cross association wrote an advertisement that implied hospitals charged them unreasonably high rates, an unwarranted assertion that undermined their position to negotiate on behalf of patients. The main point of contention was on whether reimbursement would be adequate to cover costs, as many hospitals in the St. Louis area were already struggling with high rates of uncompensated care. Relations between St. Louis' hospitals and its Blue Cross were rapidly deteriorating due to the conflict over how specifically the reimbursement system would be handled, but the market power of MHA enabled the former to make strong appeals to Blue Cross to maintain their levels of patient care. Attempts to reconcile the organizations on National Hospital Week were unsuccessful despite offers by the insurance agency to engage in a joint advertisement campaign to improve public relations.

This coincided with the expansion of federal programs for medical coverage. In 1965, the U.S. adopted the Medicare program to care for the elderly and retired; this move required increased regulation of the industry. Medicare providers had to meet certain minimum requirements to ensure an adequate standard of care for those who it covered; initial requirements included an on-staff dietician and pharmacist, and MHA gave increased priority to educational and staffing concerns in this regard. Provider laboratories required state licenses, and MHA provided several proposals to the state based on similar laws for licensure in Tennessee and Kentucky. The organization also eyed licensing laws for laboratory technicians, recommending that the state build a licensing board and recognize laboratory occupations as a health profession. Association officers and state officials discussed these licensing procedures and new requirements with state Senator Albert Spradling, a man dedicated to medical reform. This was part of a long working relationship between Ted Lloyd and Senator Spradling, both of whom worked on state programs for mental health.

Early in this time period, the organization resisted government efforts to socialize

health care. At its 1961 convention, a speaker argued for the return of the family doctor and preventive care rather than hospitalization; meanwhile, state and federal programs were being used to keep patients out of hospitals. This would reduce the overall strain on hospital facilities by diverting long-term care and chronic patients to auxiliary institutions such as old-age homes or rehabilitation clinics. Measures such as these were not flawless; in fact, the state began regulating nursing homes in 1957 with new laws placing some nursing homes out of compliance with state law. MHA and other advocates worked with the state to establish boards and standards for nursing homes that would ensure adequate safety and patient care while still easing the burden on acute care facilities. While earlier the association debated shifting a number of patients to home care or increased efforts to triage, according to the director of the Missouri Division of Health, somewhere around 80% of patients in hospitals were "there more for convenience than out of dire necessity." While this number seems high, the state of nursing and long-term care homes was dire. A speaker at the 1961 convention reported that the national need for beds in these facilities was 500,000. Accordingly, the association cooperated to establish rehabilitation and long-term care solutions and advocate for increased funding for the institutions from the state and federal governments.

While the demand for hospital beds declined in the early 1960s, the demand for skilled staffers of long-term care facilities and at-home nurses and physicians increased. By 1968, MHA organized training programs at community colleges to train nurses and laboratory technicians, anticipating the increase in demand caused by the expansion of old-age facilities. Meanwhile, the organization sponsored and participated in federal efforts to improve cardiac, cancer and other fields of care through the Regional Medical Program (RMP), a federally established agency under the Comprehensive Health Planning Act. Partnerships between the association and the RMP lasted the duration of the programs, ending as the national system of RMPs merged with the federal government's other efforts to improve health care.

MHA became more and more concerned with staffing shortages for hospitals during this time. Nursing shortages especially began to hit rural hospitals, and the association accordingly advocated for groups seeking to expand their staff, including the Green Hills Cooperative Health Care Project, which MHA advised and helped support financially. MHA sought expansion of nursing programs at local colleges and passed resolutions to allow registered nurses to administer lifesaving measures, such as CPR and emergency defibrillation, in the case of cardiac emergencies. And the association helped colleges and hospitals establish nurse training programs eligible to receive state funding under manpower laws. Medicaid and Medicare programs meant that hospitals

required further staff to receive funding, including a licensed pharmacist (either on the staff or as a consultant) and a dietician. Medicare expanded the role the federal government had in standardizing health services around the country, and Missouri was no different. The two programs were important in the development of nursing homes. As Ted Lloyd noted in 1970 citing that roughly 28% of Medicaid funding went to the state's nursing homes, cuts to Medicaid disproportionately fell upon the elderly.

Reflecting on the advances in medicine and medical policy, Lloyd was hopeful for the future and grateful for the measures governments had taken in the past. His view of the Hill-Burton Act was very positive: "Hill-Burton made it possible for people in a community to build and operate their own hospital" a measure that "has led to better facilities and tighter financial controls" on existing facilities. According to Lloyd, the law "also marked the beginning of widespread federal participation in the hospital field," an observation likely spurred by the formation of Medicare and Medicaid nearly two decades later. Lloyd noted the importance of a highly trained staff in the hospital field, saying to the *News and Tribune* that "hospital people generally — are better educated than 30 years ago, and have attained professional qualifications that weren't necessary then." Lloyd's tenure with the organization was one of vast change. When he retired in 1974, the hospital association would vote that C. Duane Dauner, a former professor at Washburn University and formerly of the Kansas Hospital Association, would become president.

In 1970, the association recognized that state-level advocacy would be insufficient to meet the needs of its hospitals. To remedy this, the hospital group sent a delegation to Washington, in cooperation with AHA, to speak directly to federal legislators on behalf of Missouri's hospitals that struggled under the Medicaid and Medicare system. Disparities between the costs of procedures covered by state and federal programs were compounded with high write-offs from insurance companies, putting hospitals at risk of running deficits. The association proposed that the Medicare and Medicaid rates be based on more recent assessments of the costs of procedures, a measure that would prevent the disparities between cost and payments. While MHA advocated for increases to payments under federal law to align more with costs, it also argued for faster turnaround times on payments to hospitals, which were often delayed anywhere from three to five months. Hospital budgets and accounting were heavily affected by changes in the Medicare system, which set relative rates of payments for hospitals. Efficient budgeting would help hospitals that were underpaid by the program to maintain high standards of care.

Under the purview of the health reform of the 1960s was the Comprehensive Health Planning Act of 1966, under which the state of Missouri established boards to help expand health care. The federal government passed the act to ensure the

expansion of manpower and services in the health field, allotting funds for states that funded health care planning services themselves. This led to increased cooperation between state health advocates, notably Senator Spradling, and health care providers. The association encouraged the expansion of Missouri's Central Health Planning Agency, which had the similar goal of expanding health care within the state. Regional health planning commissions helped to expand services and increase cooperation between local hospitals, particularly where resources were sparse, and MHA worked with them extensively. In 1975, the Office of Comprehensive Health Planning gave grants to survey the state's emergency medical programs to address how these aspects of care could be improved, a move in which the association participated. In addition, the association developed its own Comprehensive Planning Committee to coordinate between hospitals in planning expansions as well.

Relations with the state's Comprehensive Health Planning agency were sometimes strained by differences of policy and opinion. For instance, in 1976, the state agency pronounced a moratorium on the use of computerized axial tomography (CAT) scanners to evaluate standards on their use. In response, MHA condemned the action as premature, arguing that the suspension of their use would adversely affect health outcomes. To reconcile the differences, the state asked for an MHA representative to serve on a task force to discuss the guidelines for using CAT machines, to which the organization agreed. Association officials were also intimately involved in a host of other government-sponsored quality assurance procedures, including Professional Standards Review Organizations (PSROs) and the State Medical Board (of which Ted Lloyd, MHA's first chief executive, was a member). Hospitals were advised by the association's board to support efforts to decrease hospitalizations for infectious diseases by voicing their support for inoculation and vaccination of citizens, as in the case of the swine flu during 1976. Reducing hospital admissions for these preventable conditions would free beds and staff for more critically ill patients, reducing the pressure of staff shortages.

When it believed the state was less forthcoming in coordinating health planning in 1978, MHA continued to encourage members to engage with regional planning agencies. Supporting certificate of need (CON) legislation and encouraging the planning of expansions between hospitals, the association decided it would be best to sponsor a "uniform planning process" among expenditures covered and not covered under federal or state regulations. Although the state committed to health planning, it did not reinstate regulations that would have provided federal funds for hospital expansions under section 1182 of the Social Security Act. This hampered hospitals' attempts to use federal funds for expansions overseen by regional planning boards.

Renewed efforts arose in the 1970s calling for the creation of a national health insurance, a proposal brought to light in the annual convention of 1974, where William Brines — chair of the American College of Hospital Administrators — argued hospitals should take leadership. While he acknowledged "legislators … have determined that health care is a right," he advocated for the expansion of the programs that would make it universally accessible. These plans never saw fruition. Rather than increasing health care funding and expanding the payment infrastructure, the Reagan administration introduced a massive cut to funding for Medicaid, which was already suffering from decreases to funding and an inability to pay for back claims to hospitals. By 1978, a backlog of 20,000 claims were awaiting resolution, and during this time period, one claim was submitted 37 times before the state actually resolved payment.

Reforms proposed by the federal government under President Jimmy Carter complicated hospital finances even further. In 1977, the incoming president argued for limits on Medicare and Medicaid reimbursement, on which many hospitals across the country and in Missouri were still losing money. After conferring with delegations sent to Washington, D.C., the association sought to convince lawmakers not to support an arbitrary cap, releasing statements on behalf of the state's medical institutions voicing opposition. Carter's administration also made efforts to limit the general revenues of hospitals to force decreases in prices, a move that would hurt many hospitals already struggling financially. While such regulations had consequences for hospital finances, they also had significant effects on physicians' willingness to admit patients to hospitals and schedule planned procedures. A patient is less likely to schedule necessary screenings at hospitals or other facilities if they are unlikely to be able to pay. Doctors, on their part, are less likely to recommend procedures if they realize their patients are unable to pay or their institution cannot afford the procedure.

Speaking to lawmakers was not the only measure MHA took during this time period. It also sought to influence what the public thought of federal and state regulations of the health care system, creating a Political Action Committee (PAC), later known as HealthPAC, to contribute to campaigns and support political issues. For instance, the committee took actions to gauge public opinion on the expansion or protection of Medicare and Medicaid programs during times when budget cuts threatened to decrease payments.

To equip administrators with the necessary knowledge to negotiate with Blue Cross and other third-party insurance organizations, MHA sponsored institutes on negotiation and management of relations with these organizations. In attempts to prevent hospital closures and mitigate the difficulties of hospital administrators in general financial problems,

the association board additionally voted to implement a comprehensive educational program on finances, accounting and budgeting for its members. Coordinating with the state's schools of business and economics, constantly updated courses on reimbursement and planning were featured at district and statewide meetings. Along with these, the association continually updated hospital executives and financiers on developments during important negotiations, such as those with St. Louis Blue Cross in the 1970s.

Increasingly, MHA worked with Medicare Standards and Professional Standards Review Organizations (PSROs) that would become essential to securing federal funding for Medicare and Medicaid. The organizations were initially formed under the Social Security Amendment of 1972, under the argument that only institutions that could provide an acceptable quality of care may receive federal funding for these patients. The development of these PSROs as the law mandated meant that hospitals needed to ensure high-quality care across the board to remain viable. In response to new regulations regarding standards of care, the association launched programs to ensure consistent quality of care across the state, coordinating with state offices and the Quality Control Committee. Concerns for quality of care and continuing education led to the expansion of the role of MHA and coordination in the health care industry as a whole. In cooperation with the association, Missouri's Employment Security Division and Department of Education secured grants to establish nurse refresher courses under the Manpower Development and Training Act of 1962. By 1968, MHA district councils were organizing programs on how to expand education among practicing hospital physicians and nurses, developing strategic plans to improve performance of hospital doctors. During its 1973 convention, the association continued to voice its support for the continuing education of hospital professionals, arguing this increased quality of care to patients. To this end, MHA endorsed a proposal on continuing education put forth by MSMA to establish a voluntary program for the practice.

This was not the only interaction between MSMA and MHA. The groups worked together with the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS) to consolidate the licensing boards of the two physicians' organizations. They also worked together on hospital-physician relations, a recurrent theme throughout this time. By 1974, 18% of hospitals had been unionized, a measure MHA sought to prevent by putting forth serious efforts to resolve staffing problems. Coordination between hospitals meant coordination between hospital physicians, support staff and technicians; the creation of integrated care teams meant the cooperation between different hospitals' care teams, as well as within a single institution. Data sharing between hospitals would be the foundation of this interdepartmental effort to reduce admissions and improve quality of care.

In attempts to ensure adequate hospital staffing, MHA formed the Educational and Research Trust in 1965. Initially, the organization received funding from the Missouri Regional Medical Program to launch a manpower and recruitment campaign, writing brochures and giving health careers information to schools throughout the state. The goal not only was to encourage college students to enter health careers, but to promote health careers that did not require a college degree, including technicians and other support staff. Earlier educational endeavors were aimed at improving the lot of patients in MHA facilities; one major program was on dietary recommendations for patients, and others included how to improve record-keeping and care through cooperation between administrators and physicians. Funds from the trust were used to pay for advertising in newspapers, radio and television programs to foster interest in the health care industry.

With increased need for hospital services, but a scarcity of staffing and resources, hospital auxiliaries — volunteers that handled anything from public relations to minor hospital services — were essential ties between hospital and community. Auxiliaries were often tasked with aiding hospitals in delivering their messages to the people and government officials in the state. Often earning proud articles in small local newspapers, auxilians played prominent roles in connecting hospital administrators to the people through their lens as nonclinicians. They formed information networks, established libraries of useful information and volunteered hundreds of thousands of hours annually within the state's hospitals. They aided in coordinating between hospitals and civil defense as well, which were organized methods of responding to emergency situations, ranging from plans for nuclear strikes to plans for tornadoes or natural disasters. By 1970, auxilians were contributing a total of over $1 million to the state's hospitals in cash donations, with nearly a million combined volunteer hours (the organization tracked teen and adult hours separately). Donations, benefits and hospital funds were legacies of hospitals' origins as charitable institutions.

Auxiliaries were urged in 1966 to take medical self-help courses to respond to disasters. State health officials sponsored the use of auxilians to staff "package disaster hospitals" (portable hospitals stocked with emergency medical equipment) in case of disaster responses to natural or public health crises. Missouri Governor Warren E. Hearnes spoke before MHA's annual convention that year, stating that the "development of a comprehensive statewide emergency medical service system" was his number one health care priority. A senator involved in the state's program to expand EMS also "urged hospitals to take the lead in implementing" the system, stating that "the money is there. Use it!" The collaboration of hospitals and government led the latter to make available over $500,000 in state funds for this purpose, enhancing the abilities of hospitals to

increase communication and expand community ambulance services. Expanding EMS would result in the production of healthier communities and allow hospitals to fulfill their goal of serving their areas by responding to any contingency.

MHA's work with the PSROs often involved cooperation with other organizations, including the Health Care Foundation for Missouri (HFM). The hospital association decided to support the efforts of HFM to establish a PSRO support center in Missouri, which would coordinate between the five different review organizations operating there at the time. When HFM formed the PSRO Support Center in the state, the hospital association authorized one of their representatives to serve on the board of directors in cooperation with the HFM officials serving there. MHA worked with physicians and other professional groups at this time to ensure fair standards of employment, rather than encourage the formation of unions, particularly under the Taft-Hartley Act.

Essential public industries, such as hospitals, would be damaged by potential strikes or other forms of union activism, the board conceded. While recognizing this, the association identified the need to establish good working relations between doctors and the hospitals that employed them. In 1974, the organization resolved "that adequate employe[e] benefits and working conditions be provided without the influence of organizations outside the hospital." While the Kansas City and Metro St. Louis Hospital Associations passed resolutions on labor, the state association resolved that it would address potential labor conflicts between staff and administrators through three means: creating a committee to investigate labor problems, increasing communication between different councils and associations, and educating administrators on labor relations. These efforts prevented major disruptions in the provision of health care to Missouri citizens, ensuring that both hospitals and their employees were satisfied with the standards of workplaces and treatment.

With increased cooperation among hospitals designed to improve patient care, the state began tracking hospital discharges on a Keysort card system in 1963. As concerns for standards of care became more pressing after PSROs were formed in 1972, the state was put under pressure to collect and analyze discharge data, a responsibility which it decided to privatize in 1978. When the state needed a new system to track discharges, it sought MHA aid, resulting in the founding of the Missouri Health Data Corporation (MHDC) that same year. With increased needs for centralized data storage, MHA founded the Hospital Industry Data Institute (HIDI) in 1985 to "support [hospitals'] strategic planning, advocacy and health policy initiatives." Data collection has become one of the most important fields for cooperation between health systems and one of the most effective ways to improve health outcomes.

Information collected by PSROs were subsequently collected with the aid of state officials so that the hospitals and physicians involved could improve treatment. With the help of state Senator Spradling, the organization introduced a bill that would give health centers access to the data collected under federal Medicare regulations. Access to hospital data collected through the program would later be superseded by communitywide efforts to ensure quality of care through the use of HIDI and Hospital Engagement Networks that worked to decrease readmission and improve physician-patient relations. While the standards of professional and institutional conduct were important to the association's activism during the 1970s, another issue was brought to the fore by tragedy.

In 1974, a fire broke out in one of the wings of the Sac-Osage Hospital in Osceola, Missouri, killing eight patients. The institution's fire protection system prevented a worse catastrophe, but the origin of the fire was not in the building's structure itself. Instead, the origin of the fire was one of the mattresses in the damaged wing, which was not designed to be fire-retardant. MHA responded by listening to fire protection and state health officials, determining that it should pressure mattress manufacturers to use noncombustible materials. It further recommended increased use of smoke detectors and urged its members to ensure that they used the safest materials available. Board members also spoke to a spokesman of the state Division of Health to recommend they contact AHA's fire expert for further recommendations.

As health care professionals were improving standards of treatment in their field, legal consequences of improved treatments and increased usage of hospitals arose. Malpractice suits became particularly prevalent during the 1960s and '70s, placing heavy burdens on hospitals found liable for the actions of their physicians. These were considered tort offenses, civil cases that involved injury to people or their property, in which the physician and the hospital were considered jointly liable. Hospitals are considered liable under malpractice if their employee commits malpractice when on the clock, meaning that medical malpractice suits can be damaging for health centers. To this end, MHA helped develop a malpractice insurance program in 1975 called the Missouri Professional Liability Insurance Association (MPLIA) to cover its members from losses arising from malpractice suits. Expansion of this service came to fruition in 1985 with the formation of the Missouri Hospital Plan (MHP), an organization owned by member hospitals to cover general and professional liability. In addition to forming the MPLIA, Duane Dauner, the president of the association, testified before the Senate Select Committee on Malpractice in 1975. He informed the legislature of MHA's plans to support legislation limiting liability for hospitals and establishing a review process

for malpractice cases involving a group of physicians and lawyers. The legislature eventually passed a law limiting the awards in malpractice suits to $350,000, requiring sworn affidavits for tort suits.

Another emergent issue during the 1970s was the prevalence of smoking in the U.S., as recent reports ruled that smoking caused lung cancer and a host of other potential health problems. In 1975, the association appointed a committee to investigate the impact of smoking and how to limit the practice in both health care institutions and among the public. Seeking the cooperation of MAOPS and MSMA, the groups conferred on how best to confront this newly recognized health problem. Further coordination with MAOPS included support for its initiatives to reduce instances of child abuse and neglect through encouraging physicians to report potential cases to law enforcement officials. Increased public awareness of health problems shifted the association's priorities to respond to them, keeping the state's hospitals abreast of developments among the public and ahead of potential governmental interventions on certain health matters.

The association worked with the state government at this time to expand EMS, a program spearheaded by Governor Christopher Bond in 1973. Bond's attempts to expand emergency services were not the first time the association examined that program, as a speaker at their 1957 convention argued persuasively that hospitals ought to be prepared for any accidents that might happen to their patients. Health surveys conducted by the Missouri Division of Health in 1963 indicated that the majority of patients were admitted to hospitals for two conditions: digestive problems and accidental injuries. Because of this, MHA supported efforts by the state to build new facilities for treatment of digestive ailments and to increase awareness on trauma care in the state .

All the while, the health care community moved further toward providing more efficient and technologically sophisticated care for the people they served. The rising cost of health care was often attributable to what Marc Smith, MHA president from 1998 to 2009, termed the "medical arms race" between providers who often competed in expanding services to increase their market share. The values that drove these changes were those of a new president. Ronald Reagan vigorously deregulated most major industries in an attempt to increase economic growth, which had slowed during the previous decade. This led to increased competition across a number of industries, not only health care, and led to expansive for-profit health endeavors. However, this also came at the cost of cuts to the health care system overall; the small government policies of both President Reagan and then-President Bush offered significant cuts to

the overall health care budget. The major expansions would come in the mid 1990s and under the Affordable Care Act (ACA), both of which were reliant upon the state government for funding.

In 1978, MHA took a major step in establishing new permanent offices. Rather than leasing its offices as it had since 1957, the association purchased a piece of land in a western part of Jefferson City and built a two-story building to house the expanding offices of the MPLIA and MHDC. The former was MHA's new malpractice liability insurance program, and the latter had recently taken over from the state administration's Hospital Discharge Data Program earlier in 1978. The new offices gave the organization room to expand its operations, hire more permanent staff and establish new initiatives. These expansions allowed the association to increase its offerings of services to hospitals, a major concern in 1975 as a survey of member institutions indicated that 66% of them were dissatisfied with the level of services received for their dues. The E & R Trust and public relations services were soon given their own offices in the building, which still houses most of MHA's corporate activity.

The collection of health data and seminars on medical records have been a major priority of the association for much of its history. Coordinating medical records was a cost-efficient means of improving health outcomes, requiring little capital expenditure. Among its first efforts to create a medical data-sharing service, the organization purchased a computer to store discharge and treatment data for hospitals. Simultaneously, the hospital body created shared resources for training and education for hospitals, printing brochures, distributing training films, and conducting regular nursing refresher courses through the 1960s, '70s and '80s. MHA also supported hospital auxiliaries, which performed a number of essential services for the hospitals they served, forming an essential part of the industry's educational, advocacy and public awareness activities.

As the year approached 1980, the level of competition in the hospital industry increased, and rural and independent hospitals struggled to compete with larger hospitals and hospital systems from urban areas. This led to closure and consolidation of rural hospitals that previously served smaller communities and could no longer afford to remain independent. This along with the increased emphasis on new procedures and medical technologies meant that hospitals would need to further coordinate in the future, not only with regards to care for individual patients, but as a community of hospitals. Hospitals, originally founded as charitable institutions, began to enter the marketplace as businesses that had to watch for profits and avoid losses. Hospital advocates at the 1979 MHA convention argued that the industry needed to engage

with the public in a much more businesslike manner. The shift was more visible in 1978 when organizers emphasized the need for self-regulation and the establishment of accreditation for hospitals.

While the main issue for hospitals throughout most of 1957 to 1985 was the planned expansion of the health care system, the priorities began to shift during the 1970s to the cost of treatment. In 1978, Missouri hospitals undertook a Voluntary Effort campaign to decrease costs for medical treatments, establishing a series of practices to define which procedures were medically necessary. Cost containment efforts were also being addressed by the state government, which instituted CON legislation in 1979, to prevent the "unnecessary duplication of equipment and manpower." Thereby, it would decrease costs. MHA, perceiving that this might be productive, initially supported the passage of the CON law as a way of decreasing costs. Hospitals in smaller areas, it was argued, would be able to pool their resources to expand facilities under the new law, thus allowing multiple medical facilities to use the same equipment. However, quality regulations combined with CON laws became highly restrictive, decreasing the availability of services, resulting in cutbacks on hospital procedures.

Overall, hospitals were consolidating from smaller independent hospitals and voluntary hospitals into larger health systems. It was important for Charles Bowman, the man who succeeded Duane Dauner as president in 1986, to ensure that the interests of both the independent hospitals and the health systems were represented as equally as possible. It would be more difficult, however, to ensure that smaller health providers would remain open; studies done by AHA concluded that from 1980 to 1989, 445 community hospitals had closed. In Missouri, 15 were closed or merged within a four-year period. At this time, the activism of MHA was as important as ever to ensure adequate compensation by the federal and state governments for Medicare and Medicaid patients.

All the while, the federal government pressured hospitals to decrease costs and maintain high standards, putting hospitals in a difficult position; to decrease costs, they somehow had to make up revenue for uninsured people. In addition, the federal government slashed funding to Medicaid under Ronald Reagan, whose vigorous cuts to the social security system decreased payment to hospitals for those deemed indigent. This expanded the pool of the medically indigent, putting hospitals in the difficult position of balancing increased prices for commercially insured patients with an unknown amount of charity care. The goal of the association for the previous years had been primarily focused on the expansion of hospital facilities, while they now became a mixture between containing costs and maintaining the health care institutions already

in place. Simultaneously pursuing its concern with decreasing the number of indigent people in the state, the association was now put in the position of defending the state's rapidly closing hospitals. These new challenges meant that the organization was at the forefront of a new struggle between state officials and hospital administrators, even though both groups had the same goals. In the coming decades, the relationship between the government and hospitals fluctuated between cooperation and conflict.

In precursor to this, a particular episode at the association's 1972 convention featured state Senator William Cason who warned the organization that hospitals must "call the cost escalation to a screeching halt." Despite this warning, Cason was fully willing to cooperate and work with hospitals on lowering costs, promoting measures such as releasing patients to their homes sooner after surgeries with at-home postoperative care. Indicating the state might pass a law requiring insurances to cover this type of at-home care, he urged members to "get out of your rut, be innovative, explore the untried" to manage prices. Five years later, MHA sought to recover unpaid payments from the state's Medicaid system, which had failed to reimburse hospitals for services provided under the program. While it engaged in litigation, however, the association cooperated and sought compromise with legislators, particularly Senator Harry Wiggins of Kansas City. All the while, the association sought to voluntarily decrease costs through cutting the average patient stay and emphasizing cost-consciousness among doctors. It also sponsored new methods of costing and pricing that increased hospital efficiency, developing handbooks and guides by which hospitals might offer services at competitive prices despite increased overhead.

Unfortunately, these measures were insufficient to reduce the increasing costs of health care, which were made necessary by new technology and staffing requirements. Development and widespread use of CAT scans and radiology meant that hospitals needed to employ professional technicians and further train physicians to ensure quality of care steadily increased across the state's health care institutions. Hospitals needed dieticians (as per Medicare regulation), nurses, physical therapists and a host of other highly trained staff to keep up with federal regulatory standards, while federal and state funds were constantly reconfigured and rethought. The Medicare payment formula often changed, with the association supporting proposals that kept costs down and increased competition between hospitals.

National developments in the 1980s under President Reagan were constantly aimed at decreasing the cost of medical care, whether it be the taxation of insurance companies or the push to more efficiently handle Medicare and Medicaid funds. The Reagan administration's 1983 proposal to tax health insurance companies would have

forced the companies to act in a more cost-efficient manner, decreasing unnecessary expenditures to protect their margins. This, Duane Dauner speculated, would decrease unnecessary admissions of patients to hospitals, thus decreasing the need to shift funds between patients and decreasing costs overall. National efforts to expand medical care yielded to budgetary concerns about potential waste. Reagan campaigned on reducing overuse of the welfare system and the reduction of the federal deficit to manageable levels. To make good on these promises, he would later slash the budget for Medicaid, a key program in providing for the medically indigent.

By the mid-1980s, the hospital community had changed significantly. A reporter in the *St. Louis Post-Dispatch* expressed that hospitals had transitioned from "a laid-back charitable institution" to a businesslike institution that "launched aggressive and imaginative programs to market services." While it is difficult to generalize the specific movement of an entire industry, trends in health care were definitely changing both the public perception of the sector, as well as its structure and operations. Hospitals employed voluntary efforts to cut costs and began advertising programs to promote treatments, particularly to the commercially insured population. Low compensation for Medicare and Medicaid patients made these measures necessary; indigents who were either uninsured or underinsured were subsidized by higher prices charged to insured patients. While the public believed hospitals were coming to treat patients as mere "numbers," they were also becoming more attached to the communities they served, having to keep up with the changes in public health, an aging population and more sophisticated procedures.

MHA faced constant challenges when it first established permanent offices. First, under Ted Lloyd, the organization faced the problem of self-sufficiency, leading it to rework its dues system and work with other organizations to maintain its permanent status. Blue Cross and other organizations aided MHA between 1957 and 1963, when it struggled to remain solvent amid increased costs of advocating for a rapidly expanding and technologically advanced industry. Sweeping changes to government regulations and funding complicated the group's actions, as sponsorship of nursing homes rapidly yielded to sponsorship of increased state or federal funding, moving back to advocacy for small, independent hospitals as they began to close. The high cost of health care took a toll on rural hospitals, a problem that still persists today.

With the increased specialization in medicine, hospitals were encouraged to share manpower and educational and equipment resources under such proposals as the CON and the Comprehensive Health Planning Act. This meant hospitals could coordinate to plan expansions of their services and facilities, a precursor to the formation of unified

health systems in the 1990s. The needs of the state's health care facilities meant that hospital coordination would continue into the future, and advocacy by the association would need to increase correspondingly. During this period, MHA developed its specialized staff of advocates, legal professionals, data analysts, strategists and planners to ensure that operations moved smoothly. MHA President Duane Dauner developed a set of unwritten practices he called the "MHA way," a standard of professionalism and expertise that drove employees to not only better themselves but the organization they represented. The influence of these standards is felt still today, as retired CEOs Marc Smith and Charles Bowman expressed in their experiences. Its continuing emphasis on professional development and education has served the association well, whether it be in developing health care management education institutions (as it helped to do at the University of Missouri) or through its educational programs and member engagement.

Advocacy and Action
(1986–2019)

After the establishment of permanent offices, it took some time to drive roots further into the ground for the organization. During the previous period, the organization established many of the programs that would flourish later, including the Hospital Industry Data Institute and the Educational and Research Trust. During the subsequent years, the organization would establish a for-profit subsidiary, MHA Management Services Corporation (MSC) in 1987, and use these organizations to advocate directly to legislators and companies. In the meantime, a more general shift was underway in the health care industry, as hospital costs began increasing with the introduction of more sophisticated medical procedures. Cost containment became a more prominent concern in the 1980s and 90s than it had been previously, and state and local officials began demanding more transparency in pricing data. In 1982, hospital costs increased 19% from the prior year, a trend that has continued since due to improvements in medical technology. An astute observer in 1982 concluded that the main reason for increases were the new techniques practiced in hospitals across the country, comparing it to electricity.

Charles Bowman was hired as president of the association in 1985 after Duane Dauner announced he would leave the association. Bowman's philosophy when he was hired reflected, in part, the challenges of health care in the state at the time he took office. He noted that his focus was on treating every person and every hospital as an equal in the association, neither favoring the larger health systems or the smaller rural hospitals. While this was the case, many of the problems the association faced during his tenure disproportionately affected rural hospitals, especially shortfalls in Medicare funding. Another key issue of Bowman's tenure was the expanding role of Peer Review

Organizations (PROs), the successors to PSROs in the granting of Medicare and Medicaid funding. If an authorized Medicare provider did not meet a certain standard of care, a PRO would review their quality measures and audit the doctor or institution for six months.

This led MHA to strengthen its efforts to ensure consistent quality of care. And, it led the organization to coordinate with PROs in the state, with Bowman spearheading a policy that would limit the period of review to three months. When physicians were placed under professional review, the head of the PRO and Bowman would review their activities jointly, which would ensure both that there was no undue burden placed on institutions and that patients were adequately cared for. The association passed resolutions assuring both the public and the government that "Missouri hospitals … are dedicated to providing continuous high quality health care services" and that "they strive to deliver that care in the most effective, efficient and economical manner." To pursue this goal, MHA sought to combat nursing and physician shortages.

During this period of competition, concerns grew as rural hospitals lost money on Medicare patients and no longer would be able to compete with larger hospitals and hospital systems from urban areas. This led to closure and consolidation of these smaller hospitals that previously served communities; legislation concerning Medicare and Medicaid was key to saving the rural hospitals. The rural areas lost nearly four times more on Medicare patients than the city hospitals in Missouri, according to one study the association published in 1989. Difficulties continued for rural hospitals throughout this time period. MHA could not always save community hospitals despite its attempts to secure further funding for institutions facing hardship. Fixed-rate reimbursement programs from insurers meant that costs could not be effectively shifted to patients who could pay it. The organization made multiple attempts to solve these problems, sending hospital administrators and MHA members to Washington, D.C., to testify before Congress and speak to elected officials about the issues affecting Missouri hospitals. Despite this, in 1989, the federal government agreed to a $2.7 billion cut to Medicare, a program in which hospitals were already struggling to cover costs. The cuts to these programs had tangible negative consequences; in 1988 alone more than 100 hospitals across the U.S. closed, a number that decreased in later years due to advocacy.

To this end, MHA helped develop the MedAssist Effort, a campaign that advocated for the passage of an amendment to the Missouri Constitution. Although unsuccessful, under the amendment, those who were unable to pay their Medicare premiums would receive state funds to cover a portion of the remainder, and those who suffered accidental acute injuries and were otherwise unable to secure insurance would be assisted with the

potential costs of treatment or health insurance. These medical assistance programs would later be rolled into a federal program referred to as Medicare Cost Savings Programs, where people who qualified as low-income or within a certain level of need would receive federal funds for this purpose. MHA's MedAssist advocacy was rolled into the work of MSC. MSC took up several concerns, including collective bargaining agreements, lobbying efforts and coordination for political interests of the hospitals of the state. The organization would handle many of the organization's public campaigns concerning laws, ballot initiatives and regulations formulated by state officials.

These often included educational or public awareness campaigns, fulfilling one of the goals of MHA: educating the public on the needs of hospitals. This has been a concern of the organization since it was founded in 1922; even in the *Monthly Bulletin* of February 1939, the association realized that hospitals needed their constituent communities to know of their problems. The issue of the *Monthly Bulletin* realized that it was necessary to have both the support of the elected representatives and the communities that elected them. The MHA board discussed much of the same issue in a meeting in 1973, arguing that every hospital administrator should be in touch with their local state representative or senator, which was especially encouraged by Senator Spradling of Cape Girardeau. Further efforts have been made since then, as the association has sponsored, helped author and worked with legislators on particular bills, working extensively with the office of the governor, as well as leaders in the Missouri House and Senate to advocate for hospitals. It has also maintained a working relationship with the Departments of Health, Insurance and Social Services in the state government.

With increased consciousness on other social issues, MHA answered public concerns. During the 1990s, increased consciousness of climate change and environmental concerns led MHA to adopt a waste reduction and recycling system to decrease hospitals' environmental footprint. The organization increasingly looked into energy management solutions, driven both by the need to keep costs down and to maintain hospital operations during any energy crisis. In 1977, just three years after a major oil embargo against the U.S., MHA featured an article in *Missouri Hospitals* — its main publication — advocating that hospitals cooperate in reducing energy usage. The developing energy crisis in health care had been exacerbated by increased dependency of hospitals on petroleum products, which were being produced in reduced numbers.

At the same time, the state suffered from insufficient funding of the Medicaid system, the program that covered low-income families and those in need. MHA argued numerous times before the Missouri General Assembly and the governor that Missouri should expand its Medicaid system, and pursuant to this goal, the association worked

with state governmental officials to establish the Federal Reimbursement Allowance (FRA) under Charlie Bowman's leadership. Under federal law, the government would match at least 50% of funds raised for the Medicaid programs by the states. The FRA began when MHA took loans from banks and contributed it to the state Medicaid program, thus allowing a matching return on funds by the federal government. This greatly expanded the capacity of hospitals to care for the indigent, expanding the coverage for people of the state and thereby improving overall health.

Later, government rules required that matched funds under the Medicaid program be taxes from state revenues. In accordance with federal rules, the state established the provider tax program, which charged hospitals a tax for providing services in the state, and then used the revenues to secure matching funds from the federal government. The voluntary contributions of the FRA that the association had pioneered informed the state program, which passed with the support and advocacy of MHA. Federal regulations regarding Medicaid and Medicare, however, were very unstable. In 1997, the federal government reduced Medicare payments to hospitals by decreasing the rate at which they could increase, at a potential cost of over $100 billion, and cut funding to Medicaid by nearly $40 billion, both throughout the next 10 years. Meanwhile, prices increased for essential hospital supplies, including blood and equipment for new treatments. This led the association to expand its role in advocating for Medicaid and Medicare expansions; in 1999, the organization joined the push to increase care for the uninsured through the Managed Care Plus program. This program expanded care to children to prevent chronic health problems caused by nontreatment of conditions, such as asthma or ear infections and coverage for pregnant women with incomes up to and including 185% of the federal poverty level. State funds would underwrite treatment of minors whose parents could not afford health insurance, thus decreasing the amount of charity care and saving future hospital resources. In 1997, Congress approved the Children's Health Insurance Program (CHIP) to provide coverage for children in families with higher incomes. In 1998, Gov. Mel Carnahan won legislative approval to fund the CHIP program that expanded Medicaid coverage to children with families earning below 300% of federal poverty level.

All the while, state efforts to expand Medicaid were insufficient to account for decreases in revenue experienced at the federal level. An expansion passed in 1989 increased the state's Medicaid funds by $24.5 million, but this still was insufficient to cover the bills of the 20 hospitals that disproportionately treated patients covered under the program. One of these hospitals, St. Louis Regional Medical Center, would all but close its doors in 1997 and shut down its final operations in 2001. It already faced

dire prospects in 1989 when it didn't break even on costs. Public hospitals in the U.S., such as St. Louis Regional, were struggling throughout this time period; from 1980 to 1999, nearly 600 closed due to insufficient public and private funding. Today, only 962 public hospitals are sponsored by state and local governments, while in 1980, there were 1,778 public hospitals in the U.S. Further cuts to Medicare in 1997 under the Balanced Budget Act only exacerbated the current problems. By 2000, Missouri hospitals suffered revenue shortfalls, many of them operating at a loss. From January to May of 2000, five health centers closed, with another expected to close. According to Marc Smith, 79% of hospitals operating in the state saw losses on Medicare patients, a number representing a marked increase from previous numbers calculated in 1989 where under two-thirds of hospitals lost money on such patients.

More recently, state government has resisted the voluntary expansion of Medicaid. After the federal government expanded it under the ACA of 2010, the Republican-led legislature voted against the expansion of Medicaid arguing that the federal government could best use the funds elsewhere. The failure to expand Medicaid is one of the most significant factors that has limited access to health care in the state of Missouri, and it remains one of the key issues on which the association focuses. MHA not only supported the expansion of the provider tax but worked with regulatory agencies in the state to ensure that Medicaid would cover costs.

As decreased Medicaid funding affected Missouri hospitals, the state passed new restrictions on the purchase of medical equipment and building expansions under the state's CON law. Under CON, the state of Missouri implemented some restrictions to improvement of medical facilities requiring approval for several new capital investments. The expansion of specific health services over $600,000 in capital expenses or $400,000 in equipment costs required a review by committee. CON was designed to decrease health care costs overall by limiting unnecessary spending on equipment and expansions, but there was much speculation that this might be overregulation. Increased regulation, it was argued, would increase costs and could stifle innovation, defeating the very purpose of the law in the first place.

Directly resulting from both the CON law and decreased Medicaid funding, large hospital systems consolidated in the 1990s, most notably in the St. Louis area, resulting in BJC HealthCare, SSM Health and Mercy Health. This trend persisted through the end of the 20th century and into the 21st, with smaller hospitals merging or becoming affiliated with larger health systems to pool their resources. The rise of health systems would spell later issues for MHA but represented an important step forward in the delivery of health care in the state. To manage public concerns about the accessibility

of health care while ensuring quality, hospitals grouped together to increase resource pools and prevent exactly what CON was meant to combat: the duplication of staff, equipment and reduction of excess hospital capacity.

Also in the 1990s, the Hospital Association of Metropolitan St. Louis dissolved, and in 1994, MHA took over its operations and offices in St. Louis. On the other side of the state, MHA and the Kansas Hospital Association formed The Health Alliance of MidAmerica, a limited liability company. Under this new company, the Kansas City Metropolitan Healthcare Council was formed to serve the hospital needs in the bistate region. The regional office was previously operated solely by the Kansas Hospital Association. MHA has continually focused on operational efficiency for its members. From the 2000s to the present, MHA has had a low reliance on dues revenue and ranks among the highest for member satisfaction among state hospital associations.

Further implications of the CON legislation included unexpected limitations on expansion of acute care facilities and emergency services. In the aftermath of the attacks on the World Trade Center and the Pentagon on September 11, 2001, it was difficult for hospitals to expand facilities for acute care, leading MHA — in partnership with MSMA and MAOPS — to advocate for exemptions for these facilities. The fruits of long partnerships with these organizations, the association remained and remains dedicated to the expansion of services wherever they are needed, a common goal with physicians' groups. It is through the advocacy and partnership of these groups that the emergency medical system is in its present state, with EDs and trauma units trained to respond to major disasters and crises.

With increased demand for medical services, an aging population and decreased manpower, the state's hospitals began facing shortages of trained staff during the 1990s, an issue that continued into the 2000s and remains to this day. The former CEO of Ozarks Medical Center, Colin Collins, concluded that the Ozarks were "one of the most medically underserved areas in the state," where "some counties have only one doctor." MHA further supported efforts by rural hospitals to introduce more specialists into their care for communities. To increase investment in health professionals and education, the Educational and Research Trust (now known as the MHA Health Institute (MHI)) began sponsoring the education of new nurses and doctors, allocating millions of dollars in scholarships to young students over these few decades. In 2004 and 2005 alone, MHI contributed $1 million each year. It also sponsored partnerships between hospitals and colleges to expand the number of student positions in teaching hospitals and created materials and resources to raise the awareness of health professions to young people. To combat a rising nursing

shortage in the early 2000s, the association supported the expansion of accelerated degree nursing programs at colleges of nursing.

In addition, there was a concern for a lack of rehabilitation personnel, including physical therapists, occupational therapists and specialists needed to treat an aging population. The association has, as part of its efforts to raise awareness of health professions, promoted the benefits, training and inspiring stories of people who recently entered the health professions. These stories and recruitment campaigns by the organization increased interest in these fields, which have remained some of the fastest growing occupations in the state.

Smith's tenure came in 1998 after Charlie Bowman's retirement. Smith's priorities included keeping the organization together and maintaining its hand in negotiations after observing how other hospital associations were experiencing difficulties with managing the interests of both independent hospitals and large health systems. Smith helped reshape the membership of the MHA Board of Trustees in 2001 to ensure that each large health system would have a permanent seat on the board to be filled by their CEOs. Several of the larger systems in the state were starting to hire their own lobbying firms or governmental relations executives outside of MHA. Smith's move restored their faith in the organization to represent their interests and work in partnership with them, which protected both the interests of the systems and that of the independent hospitals that could less afford to hire independent lobbyists.

The leadership and engagement of the MHA Board of Trustees, who also serve as the Board of Directors of MHI and HIDI, must be acknowledged. The strong and active participation of hospital and health system chief executives in all of the association's efforts not only guides MHA's work but provides a leadership standard for hospital leaders throughout the state.

Another of Smith's major concerns was what he termed a "return to roots" of the hospital industry. In the previous two decades, the public had come to see hospitals as merely another business enterprise concerned with its bottom line, a perception not helped by the industry's own focus on being businesslike. Concerned citizens even formed groups, such as the Missouri Consumers Health Care Watch Group, whose goal was to bring attention to inefficient spending and what they saw as "unnecessary expenditures." The new CEO saw this as a crisis of public faith in the health care system itself, with recurrent malpractice crises (one in 1975, one in 1986 and one in 2002) contributing to the public perceptions of hospitals. His work on Medicare and Medicaid reform suited his goal of going back to roots; by expanding care to the greatest number of Missourians, the state's hospitals would be better able to serve their entire

communities rather than only those who could afford them. Most Missouri hospitals remained not-for-profit institutions despite their increased consolidation. To this purpose, he standardized the values of MHA and increased accountability, not only within the association's administration but among its members, revising the Code of Ethics for trustees and emphasizing the organization's responsibilities to the general public.

The association's board recognized the problem prior to Smith's more concerted efforts, putting together a special task force to determine how hospitals might improve their public image. Made up of former chairpersons, the group represented a broad array of urban and rural interests from multihospital systems and independent hospitals. Further extending the mission of community service, the association responded with caution and planning to the events of 9/11. Its main response was in its coordination of EMS across hospitals, and the implementation of a statewide emergency communications system named EMSystem, which MHA financed. The association also became a subcontractor with the state of Missouri for the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP). The grant's early years were focused on hospital acquisition of equipment and then focused on exercise and response. These efforts have gained national recognition for their comprehensive approach to preparedness. In addition, in 2002, the board resolved to secure funding to "support the state's trauma system and emergency preparedness," "increase payments to physicians who care for Medicaid and trauma patients," "support smoking cessation and early childhood development programs," and "provide drug coverage for seniors." The main priorities of the association were to ensure care for those who could not afford it, and secure funds to maintain the health of those who could not pay to maintain their own. Working with Governor Bob Holden, the association built on its former work with Governor Bond in the 1970s, which had expanded access to hospital services.

With increased concern for national security, MHA sought to secure funding for further expansions of care for emergency situations. New measures echoed those pursued during the Cold War, including attempts to prepare for biological or chemical attacks on citizens of the state. Following anthrax attacks on the U.S., this seemed an important priority, as a perpetrator later identified as a bioweapons researcher sent several letters laced with the deadly virus to members of Congress and the press, killing five people and injuring 17. These developments further increased the concern surrounding emergency medical care, driving the association to push for increased funding and emphasis on EDs. While this was the case, the association did not lose focus on other aspects of emergency care; it successfully worked with U.S. Senator

Claire McCaskill to lodge inquiries into insurance reimbursements for emergency care, specifically against health insurance company Anthem. McCaskill furthermore worked with MHA to decrease the burdens falling on rural hospitals due to the Medicare program. Anthem had restricted its payments for emergency care to hospitals, thus putting "their patients in an untenable position" of having to pay large bills for ED treatments that they could not afford.

While emergency medicine expanded, the association developed task forces to improve hospital emergency procedures. In 2013, the organization put out its emergency code implementation manual for hospitals, which standardized the code system to ensure staff could efficiently respond to medical, fire or other emergencies. The report emphasized the need to use plain language emergency codes rather than the typical color-coded ones in response to active threat or hazardous spill scenarios.

Marc Smith retired from MHA in 2009, and in his place, the association's board hired Herb Kuhn who headed MHA until October 2021. This shift in leadership brought a slight shift in priorities as well. Smith's primary focus was on the accountability of hospitals to the people of Missouri, while Kuhn's focus added to this a drive to make the government accountable for its actions regarding hospitals and health care. Smith's efforts in rehabilitating the image of hospitals as centers of care, rather than mere business entities, enabled Kuhn to further pursue his goal of lobbying the government and improving the quality of care for the whole state. The state of health care changed drastically through the expansion of the ACA, which increased Medicaid funding and significantly reduced insurance costs for large numbers of Americans.

With the importance of Medicare and Medicaid expansion, the association has continued its program to discuss the needs of hospitals directly with members of Congress. The organization also has maintained its support of state legislators and congressional delegation through its PACs. An important part of MHA's efforts has been to educate Missouri citizens in preventive measures to reduce chronic disease and preventable injuries. This included efforts to pursue anti-tobacco legislation and policies in hospitals, sponsoring campaigns on the dangers of smoking through MHI, as well as helping hospitals implement smoke-free campuses. After funds became available to the state due to the Master Settlement Agreement — the settlement signed by tobacco companies to resolve several state class-action lawsuits — MHA had an active role in the allocation of settlement funds. In 2002, the organization contributed $1.1 million to a group called Citizens for a Healthy Missouri, which proposed an initiative to increase the cigarette tax by 55 cents, a move that would have generated more than $300 million for the state to spend on EMS and disease

surveillance measures. The association has also since created further resources for cessation of smoking and on how to establish tobacco-free hospitals.

Efforts at educating the public on emerging health issues were paramount to the later MHA efforts. Its use of HIDI data enabled it to help hospitals analyze hospital quality metrics and help those that might need help with improvement programs. The association's success in establishing a dedicated program focused on hospital quality improvement resulted in MHA being honored by AHA in 2018, earning the Dick Davidson Quality Milestone Award. In addition, the Centers for Medicare & Medicaid Services awarded the association as a Network of Quality Improvement and Innovation Contractor, recognizing its health care expertise as among the best in the country. This development allowed MHA to assist its members to "transform care" in the state of Missouri, dedicating strategies, resources and time to the issue. It achieved this through the Institute for Health Improvement's Triple Aim: better health, better care, lower costs. Increased cooperation supported these three, through improved diagnostic capacities, improved prioritization of resources and increased manpower. To achieve these goals, the association has consistently dedicated resources to ensuring that high quality remained the standard at Missouri hospitals, regardless of size or resources.

Under Kuhn's leadership, MHA has pursued and received numerous federal grants that have helped support the association's work in health care quality, prevention and safety that might not otherwise have been possible.

In 2015, the group began cooperating in the Partnership for Patients Initiative under AHA's Hospital Engagement Network. Under this program, the association worked with hospitals in other states on strategies to decrease the rates of readmission and hospital-acquired conditions. With increased numbers of patients no longer needing readmission, MHA-member hospitals saved on average $1 million and maintained higher patient quality and satisfaction ratings. With the ever-increasing pace of technological advancement, improved surgical and medical capability allowed the association to advocate for improved patient outcomes. Post-surgical care is kept to a minimum with improvements to technology because many new procedures are minimally invasive, allowing hospitals to decrease the length of stays for patients undergoing operations.

Smaller hospitals, especially rural hospitals, have proven essential to Missouri's public health. But since the 1980s, they have been increasingly endangered, with many qualifying as Disproportionate Share Hospitals (DSH) (hospitals that receive a higher rate of Medicare and Medicaid patients), sole community providers, critical access hospitals (CAHs) and Medicare-dependent hospitals. Advocacy for these hospitals

has been an increasing focus of MHA's activism, including advocacy for rural mental health measures amid high rates of suicide, depression and anxiety. The association has recently concerned itself with reducing the stigma around mental health treatment in rural areas, as well as expanding mental health facilities in these areas. Rural hospitals are vulnerable to federal cuts to Medicare and Medicaid because they have fewer commercially insured patients and more uninsured citizens, leading to the association's prioritization of Medicaid expansion at the state level. Amid Republican measures to reform the ACA on the federal level, the association spoke out against proposed changes that would have impacted states that didn't expand Medicaid. The American Health Care Act, proposed in 2017, would have imposed per-person caps to Medicaid reimbursement by the federal government. Association spokespeople collaborated with a broad coalition of institutions, particularly AHA, to oppose the bill, which failed to gain the votes needed to pass in the Senate that year.

Recent trends in hospital closures have been a major concern of the federal government, especially as closures hit record highs in 2020. The National Rural Health Association concluded in 2016 that somewhere around one in three rural health centers is at risk of closing, with 673 near closure nationally. With many rural hospitals under DSH designation, government reimbursement is essential to their survival. The hospital association worked with Governor Mike Parson's administration in 2018 and 2019 to identify and solve problems facing rural hospitals in the state, which included shortages in primary and behavioral health physicians. Another problem facing these hospitals is insufficient infrastructure for medical treatment, especially internet access; increased access to the internet would ensure that patients could receive telehealth services or be monitored remotely. Parson's administration also sought to address roads and public transportation to enable rural citizens to access health care at the point of care.

The organization addressed prominent public health concerns during this period, notably the rise in opioid deaths. It recorded the cost of such treatments to Missouri hospitals and to the country at large, estimating that it cost roughly 3.5% of the nation's GDP during 2017 alone. MHA was instrumental in advocating for programs that were designed to reduce the burden of opioid use disorder (OUD) on hospitals and care providers throughout the state, including educational programs and diversion of pain management into alternative therapeutic methods, measures authorized by Governor Parson in 2019. To this end, MHA provided educational materials in partnership with the Missouri Rural Health Association, Behavioral Health Association of St. Louis and Missouri Department of Mental Health. In 2015, MHA, along with MSMA and a number of other professional organizations, issued a new set of guidelines to reduce

the number of opioid prescriptions written by emergency physicians. With this, and increased consciousness of the epidemic in 2019, the organization has since been researching even more ways to reduce use of opioids outside of emergency rooms as well. In efforts to curb the spread of the crisis and limit availability of prescription opioids, the organization sought to create a registry to track and record the number of prescriptions filled for narcotic painkillers, which would hopefully indicate areas or individuals for treatment. After many years of advocating for a prescription drug monitoring program (PDMP), which tracks prescriptions written for narcotic drugs, the state legislature finally passed a bill authorizing a PDMP in 2021.

In the field of the social determinants of opioid use, unemployment is linked to high rates of consumption, and unemployment often is caused by consumption of the drugs. This strains the already delicate situation of rural hospitals that cared for overdose victims; the most undercompensated hospitals were often saddled with the highest rates of abuse, and consequently the highest proportions of overdose patients. With its continuing focus on issues affecting rural hospitals across the state and precarious economic situations that forced several to close their doors, "medical deserts" were created, according to Kuhn, in which a number of communities had limited or no services to provide medical services. In establishing the Reimagine Rural Health initiative, the association reached out to the Missouri Farm Bureau and Missouri Chamber of Commerce and Industry in supporting rural health, acknowledging their shared goals of a high standard of rural living. As it has focused on education and prevention of acute conditions, the association has been involved in a move toward financial transparency, involving a number of member hospitals. While efforts to increase transparency in health pricing was nothing new, the organization created a website in 2016 to improve the availability of the information, with acute care hospitals contributing data. The site continues to provide hospital-specific pricing data to the public at large for a variety of chronic and acute conditions, ranging from heart attack and stroke to simple lung and parasitic infections. It also contains information regarding quality of care, including measures of readmission, unexpected hospital deaths, and reports of injury and infection following procedures. Initially, Missouri hospitals faced pressure to disclose their costs during the 1970s when cost containment became a state priority. In 1988, however, the organization began to disclose average prices for common procedures to the public, releasing them to the *St. Louis Post-Dispatch* and providing a charge report to anybody who inquired.

While transparency in pricing was an important element of the hospital association's activism at this time, it sought to encourage hospitals to discuss their efforts to invest

in their communities. The board decided in 1990 that hospitals ought to disclose the amount of charity care they contributed to the local community, as well as the number of jobs and wages they provide. The increased scrutiny placed on hospitals in the 1990s by government and business groups put additional pressure on the industry's representatives to provide more information to the public.

In 2003, offices for medical specialists operating outside of hospitals were attempting to operate in competition with hospitals. Medical specialty providers are organizations that provide treatment for medical conditions independent of hospitals, although some are affiliated with health systems. While these providers offer certain specialty hospital services, they are not under the same reporting or licensure requirements as hospitals. MHA acted to ensure both would operate under the same regulatory body to maintain adequate quality of care for both these providers and the state's hospitals.

The Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 and slightly complicated the release of health information, but HIDI's executive vice president Ken Kuebler noted that this was limited. Kuebler stated that the information collected by HIDI was very similar before and after the institution of the HIPAA Privacy Rule in 2003 but was merely stripped of patient identifiers. Public health officials and advocates could thus continue to use the information from HIDI to advocate for specific policies. This policy was viewed neutrally by the association at large since it had little impact on their political activities and only a lesser one on HIDI's efforts to gather data. While originally created to serve the data needs of Missouri hospitals and provide required data reporting to the state of Missouri, HIDI no longer only serves the state of Missouri, but the hospital associations and state agencies of multiple other states, making it one of the largest collectors of hospital data in the U.S.

In its more recent years, MHA has used hospital data along with data from other sources to analyze health care issues in Missouri. This has resulted in multiple reports exploring issues such as rural mental health and adverse childhood events. The association also launched a website, exploreMOhealth.org, in partnership with the Missouri Foundation for Health and the University of Missouri. Providing data from the Missouri Foundation for Health, the U.S. Census Bureau and HIDI, it allows consumers and researchers to access data on health problems throughout the state's 114 counties and the City of St. Louis. It also pinpoints specific ZIP codes where chronic conditions correlate to location, which aids researchers studying the social determinants of health, where a patient's location or ZIP code could help clinicians better understand the patient's likelihood for certain conditions. Other studies and information made available by HIDI were used by BJC HealthCare and Washington University Physicians,

in collaboration with the MHA, to pinpoint socioeconomic factors that may affect hospital readmissions. The study found that post-discharge care was one of the primary areas for improvement in care for those of lower socioeconomic status.

MHA and HIDI continue to find ways to better organize the delivery of health care and to safeguard standards of care across health systems with a goal to "hold organizations accountable for the health systems they create," and by doing so, to "prevent chronic costly diseases, maximize outcomes and improve health across the life spans of Missouri patients." This information infrastructure has allowed not only hospitals, but public health officials, doctors and researchers to request information in the pursuit of creating more efficient delivery of care. This accountability has been a key focus of Kuhn's tenure.

One of the hallmarks of both Marc Smith's and Herb Kuhn's tenures was a focus on membership satisfaction, with the association starting a biannual member satisfaction survey that has seen consistently higher excellent scores from its members from the early 2000s through the next two decades.

From Present to Future

(2020 and beyond)

The COVID-19 pandemic of 2020-2021 has made people realize even more so that hospitals are at the center of communities. The development of major health systems and cooperation between these groups has been necessary to coordinate where national, state and local resources are needed and delivered. This has not only saved lives, but tied health services and policies closer together, as hospitals banded together in St. Louis, Kansas City and across the state of Missouri to respond to the pandemic and advise the public on prevention and treatment. Case and testing statistics made HIDI an essential part of MHA's response to the pandemic. The organization has made repeated recommendations to state and local public health officials advocating policies to help them weather the storm and avoid surges.

MHA began monitoring COVID-19 as soon as it saw the potential for its spread to the U.S. in general and Missouri in particular. The first significant surge in COVID-19 cases in the state occurred in late June and early July of 2020, but this was not the most difficult part of the pandemic. The winter of 2020-2021 brought the highest rates of infections, hospitalizations and deaths for the state, but this surge was mitigated in part by the arrival of COVID-19 vaccines. Vaccination events and education were supported both by MHA and MHI. Coordinating with state officials, the organization provided surge response planning and materials to hospitals throughout the state, both in rural and urban areas. During the surge of July 2021, MHA advised public health officials to take strong measures to limit the strain on hospitals. It noted that the state of Missouri's "entire health care system will be very near the brink" of being completely overwhelmed "if the rest of the state follow[ed]" the trends it had seen in localized pockets. Several local governments reacted to this with increased caution by reinstituting mask mandates.

The continuing pandemic has adversely affected hospitals throughout the country; among these, it has placed great burdens on small, independent rural hospitals. The hospital association reported to the public that approximately 50% of Missouri's rural hospitals "already had negative operating margins before the coronavirus hit." Patient volumes and financial troubles experienced under the pandemic threatened (and as of this writing still threaten) the viability of the state's rural hospitals. Despite the best efforts of MHA, many rural hospitals still treat high numbers of the uninsured.

Association efforts for emergency suspension of regulations were successful in attaining waivers for rules that restricted nursing roles, bed capacity and other key limitations. These regulations would have posed further difficulties to hospital resources that were straining at the height of the pandemic and in the subsequent surges. Hospitals could temporarily increase their total bed and ICU capacities to meet the challenge of rising cases and virus variants. The association advocated for the relaxation of requirements for practical nurses and support personnel in hospitals, so that more hands would be able to handle more patients on an emergency basis. MHA helped hospitals access funding from the federal government through the Provider Relief Fund, established under one of several stimulus bills designed to lessen the pandemic's economic impact. The focus of the association has been firmly in the interests of public health and adequate health treatment of the pandemic.

MHA sent newsletters describing the state of infections, hospitalizations and hospital capacity to the public and government entities of which HIDI was essential. Cooperation with professional organizations, including the Association of Counties, Missouri Chamber of Commerce and Industry, and Missouri Farm Bureau led to the endorsement of the Mask Up Missouri Campaign, a joint effort in support of public mask-wearing that began in July of 2020.

President Herb Kuhn has speculated that the future of hospitals will bring only greater need for collaboration, not only between hospitals, but other institutions as well. MHA has built partnerships with a broad coalition that Kuhn believes are here to stay. The significant engagements with the Missouri Farm Bureau and Missouri Chamber of Commerce and Industry, among others, are illustrative of this. MHA and these groups banded together during Kuhn's tenure regarding the pandemic, as well as in campaigns to promote rural health and hospitals, but their shared interests do not end there. With increasing challenges to public health, whether the opioid crisis or COVID-19, the association and its partners have seen an increasing need to collaborate to achieve their goals. This was also the case with the recent successful ballot initiative to expand Medicaid in Missouri. A number of diverse groups, including MHA partnered

to support the ballot initiative, which passed in 2020. A main focus of Kuhn was the maintenance of good working relationships, ensuring that the association's partners felt appreciated in their collaborations.

Although the recent Medicaid expansion has been challenged in the courts by some legal analysts and lawmakers, the Missouri Supreme Court ruled in July 2021 that the state's legislature must comply with the initiative passed in 2020. Governor Parson recognized this earlier, encouraging the legislature to pass a budget to ensure Medicaid expansion funding nearly eight years after the Obama administration made the matching funds available. Legal wrangling has ensued, but the state is now enrolling newly eligible Missourians in the program. The state association will continue its advocacy work in concert with AHA representatives in Washington, D.C., working to relieve hospitals still struggling under the burden of increasing COVID-19 infections and massive operating deficits due to the essential reduction in nonemergent procedures.

Ensuring a high level of engagement between employees, health systems, the public and advocates in the state and national capitals has been essential for the past and ongoing work of MHA. Mutual areas of public concern have brought the association to work with the state on a variety of issues, including the prevention and awareness of human trafficking. Because roughly 88% of victims of human trafficking have interactions with the health care system, of which the majority are in hospitals, the state formed a Missouri Hospital Human Trafficking Taskforce to investigate and strengthen measures against the crime in the state's medical institutions. This resulted in the development of a toolkit "designed to break down misconceptions" on the practice in August 2021. These efforts strengthened relationships between the state government and the association, and the partnership is expected to last into the future.

MHA has taken steps recently to address systemic racial and economic inequalities in the health care system, advocating for increased attention to underserved communities through addressing health equity. Marginalized racial, ethnic and economic communities are often the first to lose their health care institutions or suffer from lack of access to preventive services. This means that these communities also tend to suffer the worst health outcomes, with high rates of infant and maternal mortality, obesity, smoking, and diabetes — all consequences of social determinants of health. Kuhn's leadership philosophy has been influential in this work. Among the most prominent of his beliefs is that partnerships with other organizations are "absolutely critical" to advocacy in any field, not limited to the public health issues that have come to the fore. He laid out a simple goal best explained through an analogy. He explained that, in 20 years, the organization might not have the same staff, the same CEO or administrators,

but his goal was to make the organization like a laptop computer with an Intel logo on it. His vision was that the hospital's membership in the association would demonstrate that MHA is essential to the hospital. While this goal is still in process, future efforts will continue to emphasize the close relationship between the hospital, community and association.

Epilogue

It has been a century since those 50 hospital representatives met in St. Louis in 1922. Hospitals and hospital systems have come and gone, grown and shrunk, and administrators have succeeded one another over the past hundred years. Hospitals themselves have changed, originating as charitable institutions, then developing into more sophisticated not-for-profit and, in some cases, for-profit organizations. Technologically sophisticated equipment has changed the face of medicine, where patients no longer require long-term hospital stays for many procedures that are no longer invasive. Health care also has become far more readily available because of technology. Hospitals are even more the centers of their communities today than they were in the past, often employing the most people in their respective areas of operation and providing health care screenings and prevention information to their communities. While the industry moved forward, MHA pushed for its members and supported their innovation. The organization anticipated pushes for transparency and cost management, improving efficiency, and moving faster than the government to improve quality standards for patients. In addition, it has sought to keep the government itself accountable, fighting for the expansion of Medicaid and rallying support for rural hospitals as they battle to serve their communities.

Whether under its first president, Louis Burlingham, or any of its executive leaders, MHA has had a single simple goal: make health care services accessible to all Missourians. The strategies and priorities around this goal have changed. Earlier, the hospitals had fewer options to care for the indigent, but more recently, indigent care has expanded significantly. During the Second World War and early Cold War Era, the organization emphasized the expansion of manpower and use of rationed resources to endure through the period. More recently, hospitals have expanded their emergency

preparedness and response with the planning and funds that both have come from MHA-led programs. The association has aided the government as well as the public by collecting entry and discharge data from hospitals, first under the MHDC and later under HIDI, an innovation that it has spearheaded since 1978. HIDI has since expanded beyond the bounds of the state of Missouri, a reflection of its expertise in health care data collection. With all these programs and sponsorships and movements, the goal of MHA has remained the same: helping hospitals serve the public. Driving advancement in care and public health policy, the association has been serving its members and the people of Missouri for 100 years now and will continue to do so long into the foreseeable future, building on its history of cooperation. Its lasting partnerships with the Missouri Farm Bureau, Missouri Chamber of Commerce and Industry, Missouri Rural Health Association, and many others will serve it well in the years to come. Under Herb Kuhn, Marc Smith, Charlie Bowman, Duane Dauner and Ted Lloyd, these working relationships have strengthened beyond just temporary partnerships into half-century and century-long ties between organizations with similar goals. In mid-2021, Kuhn announced his retirement, and the Board of Trustees hired Jon D. Doolittle, who had been serving as the board chair, to serve beginning in October 2021.

Given the increased importance of data and information management in the health care industry, Doolittle is poised as a perfect choice to lead the organization into the next decade. As of this writing, it is difficult to get a clear picture of the issues he and the association will face, but one thing is certain: The association will continue to move hospitals forward.

Throughout its history, MHA has struggled against seemingly insurmountable problems: ineffective government intervention, supply and staffing shortages, and increased competition among hospitals. In all of these, it has made significant progress, defeating state inaction to aid the uninsured; working to increase the number of nurses and expanding nurse training programs; and maintaining balance between small and rural, critical access, independent, for-profit, small urban hospitals, and larger health systems. Ensuring professional quality and maintaining the health infrastructure of the state has taken a highly educated, efficient staff who have been dedicated to their work in health care and for society as a whole. The organization will remain crucial to the hospital community's response, as well as governmental responses to the issues that will arise in the future.

One thing has been certain. Through all the interviews, newspaper articles and various other sources that I've sifted through in this effort, I have come to realize that the hospital association is only as good as its staff. Every CEO or representative I've

interviewed in my research has said that the people who worked at MHA have been the best people they've worked with in their whole careers. MHA's employees, officers and staff have consistently demonstrated skill, professionalism and dedication through their work together, whatever their rank or position in the organization. In my own experiences, I can tell that they have high standards for their work, and that their dedication to hospitals and public health is second to none. Whatever new (or old) challenges present themselves to MHA, it will be well equipped to handle them.

MHA Chief Executive Officers

1957-1974
Ted O. Lloyd

1975-1985
C. Duane Dauner

1986-1997
Charles L. Bowman

1998-2009
Marc D. Smith

2009-2021
Herb B. Kuhn

2021-Present
Jon D. Doolittle

MHA Senior Leadership

Mary C. Becker
Senior Vice President of Strategic Partnerships and Communications
July 1998 - Present

Michael R. Dunaway
Senior Vice President of Field Operations
April 1990 - January 2019

Dwight L. Fine
Senior Vice President of Governmental Relations
January 1985 - September 2009

Kenneth L. Kuebler
Executive Vice President of Hospital Industry Data Institute
September 1985 - May 2008

Daniel R. Landon
Senior Vice President of Governmental Relations
August 1993 - December 2021

Kathleen C. Poff
Senior Vice President of Administration and Chief Financial Officer,
May 1982 - Present

Leslie L. Porth
Senior Vice President of Quality, Safety and Research
March 1999 - December 2021

Theresa J. Roark
Senior Vice President of Research Data and Information Services
April 2008 - Present

Gerald M. Sill
Senior Vice President and General Counsel
April 1981 - August 2011

Dian Volkmer
Senior Vice President
March 1977 - August 1997

Chairs of the MHA Board of Trustees

1922 L.H. Burlington, M.D., Barnes Hospital, St. Louis

1923 L.H. Burlington, M.D., Barnes Hospital, St. Louis

1924 Rush Castelaw, M.D., Kansas City Christian Hospital, Kansas City

1925 Rush Castelaw, M.D., Kansas City Christian Hospital, Kansas City

1926 B.A. Wilkes, M.D., Missouri Baptist Hospital, St. Louis

1927 B.A. Wilkes, M.D., Missouri Baptist Hospital, St. Louis

1928 J.R. Smiley, St. Luke's Hospital, Kansas City

1929 E.P. Hayworth, Willows Maternity Hospital, Kansas City

1930 Fred S. Clinton, Oklahoma Hospital Association, Tulsa

1931 E. Muriel Anscombe, Jewish Hospital of St. Louis, St. Louis

1932 E.E. King, Missouri Baptist Hospital, St. Louis

1933 W.J. Grolton, Missouri Pacific Hospital, St. Louis

1934 W.J. Grolton, Missouri Pacific Hospital, St. Louis

1935 Reverend R.D.S. Putney, St. Luke's Hospital of St. Louis, St. Louis

1936 L.C. Austin, Menorah Medical Center, Kansas City

1937 T.J. McGinty, Southeast Missouri Hospital, Cape Girardeau

1938 Reverend Paul Zwilling, Deaconess Hospital, St. Louis

1939 Frank R. Bradley, M.D., Barnes Hospital, St. Louis

1940 Paul E. Robinson, Neurological Hospital, Kansas City

1941 Florence E. King, Jewish Hospital of St. Louis, St. Louis

1942 L.C. Austin, Menorah Medical Center, Kansas City

1943 Florence E. King, Jewish Hospital of St. Louis, St. Louis

1944 T.J. McGinty, Southeast Missouri Hospital, Cape Girardeau

1945 Hal G. Perrin, Kansas City General Hospital, Kansas City

1946 H.J. Mohler, Missouri Pacific Hospital, St. Louis

1947 Curtis H. Lohr, M.D., St. Louis County Hospital, St. Louis

1948 Edward A. Thompson, St. Joseph Hospital, St. Joseph

1949 Mabel H. Mooney, Levering Hospital, Hannibal

1950 Frank R. Bradley, M.D., Barnes Hospital, St. Louis

1951 C.E. Copeland, Missouri Baptist Hospital, St. Louis

1952 C. Steacy Pickell, Fitzgibbon Memorial Hospital, Marshall

1953 David Littauer, M.D., Jewish Hospital of St. Louis, St. Louis

1954 Herbert S. Wright, Southeast Missouri Hospital, Cape Girardeau

1955 Horace S. Burgin, St. Louis Maternity Center, St. Louis

1956 Bertha Hochuli, R.N., Boone County Hospital, Columbia

1957 Harry E. Panhorst, Barnes Hospital, St. Louis

1958 G.O. Lindgren, Trinity Lutheran Hospital, Kansas City

1959 Keyton Nixon, Audrain Medical Center, Mexico

1960 Harry M. Piper, St. Luke's Hospital of St. Louis, St. Louis

1961 A. Neal Deaver, Independence Sanitarium and Hospital, Independence

1962 William J. Gnadt, Bonne Terre Hospital, Bonne Terre

1963 John B. Warner, Firmin Desloge Hospital, St. Louis

1964 Robert E. Adams, Research Medical Center, Kansas City

1965 Elmer Paul, Burge-Protestant Hospital, Springfield

1966 John R. Eckrich, Lutheran Medical Center, St. Louis

1967 James R. Rich, North Kansas City Memorial Hospital, North Kansas City

1968 Charles R. Broome, Jr., Callaway Memorial Hospital, Fulton

1969 Robert J. Guy, Missouri Baptist Hospital, St. Louis

1970 Warren S. Hinton, Methodist Medical Center, St. Joseph

1971 Carl A. Virgien, Springfield Baptist Hospital, Springfield

1972 Sister Estelle Marie Vosen, SSM, St. Mary's Health Center, St. Louis

1973 Hamilton V. Reid, Baptist Memorial Hospital, Kansas City

1974 Ralph F. Kiesling, Charles E. Still Osteopathic Hospital, Jefferson City

1975 Carl C. Rasche, Deaconess Hospital, St. Louis

1976 George H. Yeckel, Menorah Medical Center, Kansas City

1977 Neil C. Wortley, Lester E. Cox Medical Center, Springfield

1978 David A. Gee, Jewish Hospital of St. Louis, St. Louis

1979 Earl E. Horton, Independence Sanitarium and Hospital, Independence

1980 William D. Blair, Farmington Community Hospital, Farmington

1981 Robert E. Frank, Barnes Hospital, St. Louis

1982 E. Wynn Presson, Research Medical Center, Kansas City

1983 Thomas J. Hesselmann, St. Joseph Hospital, St. Joseph

1984 Sister Betty Brucker, FSM, St. Mary's Health Center, Richmond Heights

1985 Dan H. Anderson, Baptist Medical Center, Kansas City

1986 Harold L. Jones, Missouri Delta Medical Center, Sikeston

1987 Norman E. McCann, Missouri Baptist Hospital, Town and Country

1988 Joseph E. Lammers, Independence Regional Health Center, Independence

1989 Ed Farnsworth, Still Regional Medical Center, Jefferson City

1990 Fred L. Brown, FACHE, Christian Health Services, St. Louis

1991 N. Gary Wages, St. Mary's Hospital of Blue Springs, Blue Springs

1992 Keith Adams, Oak Hill Hospital, Joplin

1993 John T. Farrell, St. John's Mercy Medical Center, Creve Coeur

1994 Richard M. Abell, Saint Joseph Health Center, Kansas City

1995 Don L. Sipes, Saint Luke's Northland Hospital – Smithville

1996 Alan W. Brass, Children's Hospital St. Louis

1997 Ross P. Marine, DHL, Truman Medical Center East, Kansas City

1998 James W. Wente, Southeast Missouri Hospital, Cape Girardeau

1999 Ronald B. Ashworth, Sisters of Mercy Health System, St. Louis

2000 G. Richard Hastings, Saint Luke's – Shawnee Mission Health System, Kansas City

2001 Donald J. Babb, Citizens Memorial Hospital, Bolivar

2002 William C. Schoenhard, FACHE, SSM Health Care, St. Louis

2003 Richard W. Brown, FACHE, Health Midwest, Kansas City

2004 Joseph W. Crossett, Liberty Hospital, Liberty

2005 Ronald J. Levy, SSM Health Care – St. Louis

2006 John W. Bluford, Truman Medical Centers Inc., Kansas City

2007 Michael E. Henze, Lake Regional Health System, Osage Beach

2008 Crystal Haynes, Saint Louis University Hospital, St. Louis

2009 David Carpenter, North Kansas City Hospital, Kansas City

2010 James Ross, University of Missouri Health Care, Columbia

2011 Gary Olson, St. Luke's Hospital, Chesterfield

2012 Myra Evans, Community Hospital Association-Fairfax

2013 Mark Laney, Heartland Health, St. Joseph

2014 Randy Wertz, Golden Valley Memorial Healthcare, Clinton

2015 Chris Howard, SSM Health Care, St. Louis

2016 Julie Quirin, Saint Luke's Health System, Kansas City

2017 Patrick Carron, Perry County Memorial Hospital, Perryville

2018 Jeffrey Johnston, Mercy East Communities, St. Louis

2019 Steven Edwards, CoxHealth, Springfield

2020 Charles Shields, Truman Medical Center, Inc., Kansas City

2021 Jon D. Doolittle, Mosaic Medical Center – Albany

2022 C. Todd Ahrens, Hannibal Regional Healthcare System, Hannibal

Missouri Hospital Chairs of the American Hospital Association

1929

Louis H. Burlingham, M.D.

Barnes Hospital
St. Louis

1955

Frank R. Bradley, M.D.

Barnes Hospital
St. Louis

1999

Fred L. Brown

BJC Health System
St. Louis

2002

Sr. Mary Roch Rocklage, RSM

Sisters of Mercy Health System
St. Louis

2011

John W. Bluford

Truman Medical Centers, Inc.
Kansas City

2020

Melinda L. Estes, M.D.

Saint Luke's Health System
Kansas City

Distinguished Service Award Recipients

1976
Sister Estelle Marie Vosen, FSM
St. Mary's Health Center
St. Louis

1977
Cullen Coil
Carson and Coil
Jefferson City

1978
Carl C. Rasche
Deaconess Hospital
St. Louis

1979
Robert E. Adams
Research Hospital and Medical Center
Kansas City

1980
Gerald J. Malloy (posthumously)
Hospital Association of Metropolitan
St. Louis

1981
Neil C. Wortley
Lester E. Cox Medical Center,
Springfield

1982
John R. Eckrich
Lutheran Medical Center
St. Louis

1983
Paul F. Detrick
Christian Health Services
St. Louis

1984
C. Duane Dauner
Missouri Hospital Association
Jefferson City

1985
Robert E. Frank
Barnes Hospital
St. Louis

1986
David A. Gee
Jewish Hospital of St. Louis
St. Louis

1987
Dan Anderson
Baptist Medical Center
Kansas City

1988
Norman E. McCann
Missouri Baptist Hospital
Town and Country

1989
Sister Betty Brucker, FSM
St. Mary's Health Center
Richmond Heights

1990
Harold L. Jones
Missouri Delta Medical Center
Sikeston

1991
O. David Niswonger
Southeast Hospital
Cape Girardeau

1992
Sister Catherine Durr, CSJ
St. Joseph Hospital
St. Louis

1993
Keith Adams
Oak Hill Hospital
Joplin

1994
Donald J. Babb
Citizens Memorial Hospital
Bolivar

1995
Fred L. Brown
Christian Health Services
St. Louis

1996
Richard M. Abell
Saint Joseph Health Center
Kansas City

1997
Charles L. Bowman
Missouri Hospital Association
Jefferson City

1998
G. Richard Hastings
Saint Luke's Health System
Kansas City

1999
Douglas A. Ries, FACHE
SSM Cardinal Glennon
Children's Medical Center
St. Louis

2000
Don L. Sipes, FACHE
Saint Luke's Northland Hospital
Smithville

2001
Lowell C. Kruse
Heartland Health
St. Joseph

2002
Robert P. Dunn
Hospital Services Group, Inc.
Jefferson City

2003
Sister Mary Roch Rocklage, RSM
Sisters of Mercy Health System
St. Louis

2004
Barbara Weaver
Boone Hospital Center
Columbia

2005
Dwight L. Fine
Missouri Hospital Association
Jefferson City

2006
Steven H. Lipstein
BJC HealthCare
St. Louis

2007
William C. Schoenhard, FACHE
SSM Health Care
St. Louis

2008
Marc D. Smith, Ph.D.
Missouri Hospital Association
Jefferson City

2009
John W. Bluford
Truman Medical Centers, Inc.
Kansas City

2010
Sister Mary Jean Ryan, FSM
SSM Health
St. Louis

2011
Gary D. Duncan, FACHE
Freeman Health System
Joplin

2012
David Carpenter
North Kansas City Hospital

2013
Michael E. Henze
Lake Regional Health System
Osage Beach

2014
Gary R. Olson, FACHE
St. Luke's Hospital
Chesterfield

2015
Lynn Britton
Mercy
St. Louis

2016
Steven C. Bjelich, FACHE-D
Saint Francis Healthcare System
Cape Girardeau

2017
Mark Laney, M.D.
Mosaic Life Care
St. Joseph

2018
Randall L. O'Donnell, Ph.D.
Children's Mercy Hospital
Kansas City

2019
Christine M. Candio, R.N., FACHE
St. Luke's Hospital
Chesterfield

2020
All Missouri Hospitals – COVID-19 Response

2021
Herb B. Kuhn
Missouri Hospital Association
Jefferson City

Corporate History

Educational and Research Trust of the Missouri Hospital Association a 501(c)(3) Not-for-profit Organization

- Formed in 1965
- Name changed to MHA Center for Education in 2002
- Name changed to MHA Health Institute in 2017

Hospital Industry Data Institute

- Formed in 1985

Shared Hospital Activities & Regional Efforts, Inc. (SHARE) — Dissolved in January 1988 — Programs Transferred to MHA Management Services Corporation

- Programs included:
  - Missouri Hospital Purchasing Council (MHPC)
  - SHARE – Special Reimbursement Programs (Children's Hospitals)
  - MHETN — Missouri Health and Education Television Network (Formed in 1983)

MHA Management Services Corporation (MSC)

- Formed January 1988

Political Action Committee for Health of the Missouri Hospital Association (HEALTHPAC)

- Formed January 1980
- A state PAC

Political Action Committee of the Missouri Hospital Association (PAC of MHA)

- Formed in February 1994
- A federal PAC

Issues PAC of the Missouri Hospital Association

- Formed January 2001
- Name changed in 2004 to Health Care Issues Committee of the Missouri Hospital Association
- PAC formed to support ballot issues

St. Louis Metropolitan Hospital Council

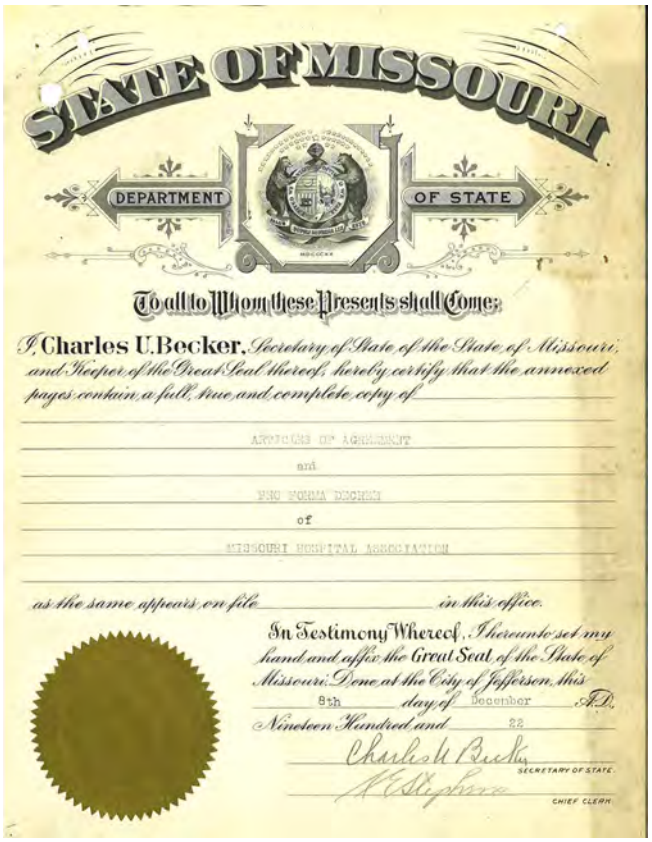
- Operations assumed by the Missouri Hospital Association in 1994 after the Hospital Association of Metropolitan St. Louis dissolved

The Health Alliance of MidAmerica LLC

- A limited liability company formed in March 1999, jointly owned 50/50 between the Missouri Hospital Association and the Kansas Hospital Association
- The Kansas City Metropolitan Healthcare Council was formed under The Alliance as a joint bistate office of the two state hospital associations
- APS is a purchasing service company for health care organizations jointly owned by the Kansas Hospital Association & the Missouri Hospital Association

Healthcurve Analytic LLC

- A limited liability company formed in April 2014, jointly owned 50/50 between the Missouri Hospital Association and the Illinois Hospital Association
- In December 2016, IHA submitted a request to withdraw from the LLC, which was accepted by MHA
- Dissolved in June 2017



STATE OF MISSOURI

DEPARTMENT OF STATE

To all to Whom these Presents shall Come:

I, Charles U. Becker, Secretary of State of the State of Missouri, and Keeper of the Great Seal thereof, hereby certify that the annexed pages contain a full, true and complete copy of

ARTICLES OF AGREEMENT

and

FOR FORMA DOCHEN

of

MISSOURI HOSPITAL ASSOCIATION

as the same appears on file in this office.

In Testimony Whereof, I hereunto set my hand and affix the Great Seal of the State of Missouri. Done at the City of Jefferson, this 8th day of December A.D. Nineteen Hundred and 22

Charles U Becker SECRETARY OF STATE

CHIEF CLERK

1922 State of Missouri Articles of Incorporation.

MONTHLY BULLETIN
of the
Missouri Hospital Association
Official Publication of the Missouri Section of the American Hospital Association

Volume 1 August, 1938 Number 1

From Our President

Hail to the Missouri Hospital Association Bulletin! May it live long and prosper!

Your editor has asked your president for a contribution to the President's Corner of your Bulletin. What could be more appropriate than a cordial greeting on the occasion of our first inviable meeting? Indeed, your president welcomes the opportunity to greet you, co-workers in the hospital field, through the columns of your publication. It is his wish, as well as that of the entire official family of the Missouri Hospital Association, to become acquainted with every hospital administrator, supervisor, employee and trustee in Missouri, so as to make common cause for the things we represent. We believe that through the medium of the Missouri Hospital Association Bulletin, we shall be able to keep in closer touch with one another.

Meet Your Official Family

The names of your official family appear at the masthead of your Bulletin. Would that space permitted a word of kindly introduction to our readers. However, it is hoped that as time goes on we may meet and learn to hold each of the officials in the esteem they deserve for the things they represent.

Candidly, your president was filled with fear and timidity when informed of his appointment as the presidency of the Missouri Hospital Association. How was he to lead an organization which was almost entirely strange to him and in which he had been only passively active?

Only after the special meeting of your officers at the Missouri Baptist Hospital in St. Louis, June 30th, did he gain the stimulus to carry on; for he beheld in his co-workers a splendid group of men and women who he believes are ready to give the best in their possession to the health program in Missouri. Committees, the personnel of which appear in another column, were appointed, and we have reasons to believe if all appointees will take hold in the spirit that may reasonably be expected of them, we shall have

(Continued on Back Page)

ASSOCIATION ADOPTS FOUR-DISTRICT PLAN

Executive Committee Announces New Program for All of Missouri's Hospitals; District Meetings To Be Held

Meeting at the Missouri Baptist Hospital in St. Louis on June 30th, the officers and trustees of the Missouri Hospital Association divided the state into four districts, each district to have a chairman responsible for the organization and selection of that district.

This move is intended to replace an unwieldy, state-wide organization with four compact, cooperative units.

The districts, with the chairman and counties included in each, are:

NORTHEAST DISTRICT
Chairman: Miss Charlotte Kane, Assistant Hospital Director, Columbia.
Counties: Putnam, Schuyler, Scotland, Clark, Sullivan, Adair, Knox, Lewis, Lincoln, Macon, Shelby, Marion, Chariton, Randolph, Monroe, Ralls, Howard, Boone, Audrain, Pike, Clairborne, Montgomery, Warren, Lincoln.

SOUTHEAST DISTRICT
Chairman: T. J. Mellody
Counties: Dunklin, Pemiscot, St. Charles, St. Louis, Jefferson, Crawford, Washington, St. Francois, Ste. Genevieve, Dent, Iron, Madison, Perry, Stoddard, Reynolds, Wayne, Bollinger, Cape Girardeau, Carter, Oregon, Ripley, Butler, Scott, Mississippi, New Madrid, Pemiscot, Dunklin.

SOUTHWEST DISTRICT
Chairman: Miss Josephine Yeiss, Freeman Hospital, Joplin.
Counties: Howell, Oregon, Texas, Shannon, Wright, Douglas, Christian, Lawrence, Barry, Stone, Taney, Greene, Webster, Laclede, Pulaski, Phelps, Texas, Dent, Dallas, St. Clair, Henry, Hickory, Benton, Cooper, Miller, Maries.

NORTHWEST DISTRICT
Chairman: Paul E. Robinson, Neurological Hospital, Kansas City.
Counties: Clay, Platte, Jackson, Lafayette, Saline, Pettis, Johnson, Henry, Cass, Bates, Vernon, Barton, Jasper, Newton, McDonald, Barry, Stone, Taney, Greene, Dade, Cedar, Polk, Hickory, Benton, Pettis, Cass, Johnson, Lafayette, Saline, Ray, Carroll, Chariton, Linn, Sullivan, Grundy, Mercer, Harrison, Daviess, DeKalb, Clinton, Caldwell, Livingston, Gentry, Worth, Harrison, Mercer.

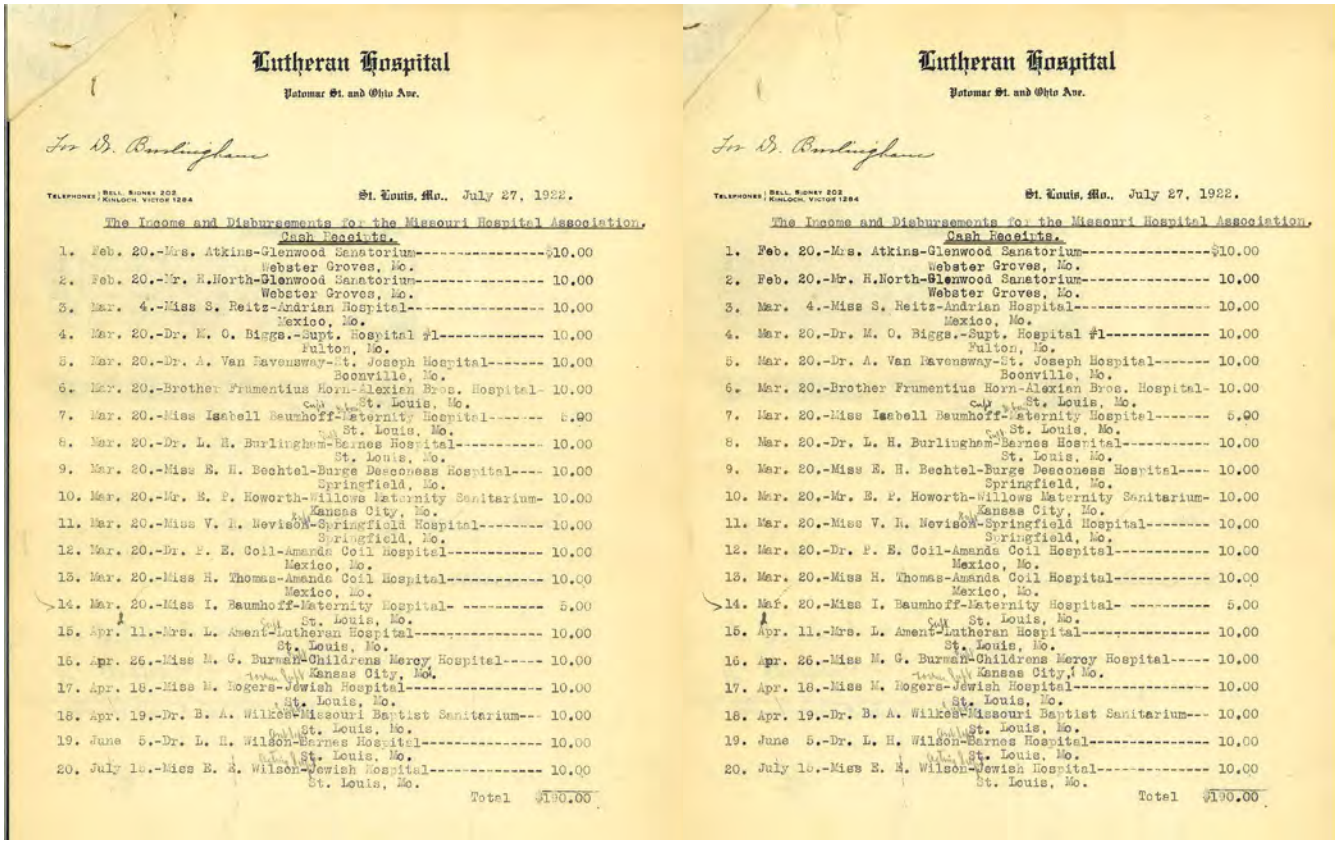
Activities in each district are being planned by the chairman, and it is hoped the hospital workers of each may be drawn together at a central point for regular meetings, at which hospital problems of the district will be discussed, and prominent speakers will be heard.

Send In Your Lists

Administrators of member hospitals are requested to send to the publication office of the Monthly Bulletin the names and addresses of trustees, departmental heads and others connected with their hospitals to whom they want the Monthly Bulletin sent.

AUG 13 1938

1922 Missouri Hospital Association Monthly Bulletin.



Lutheran Hospital
Potomac St. and Ohio Ave.

Dr. W. Burlingham

TELEPHONES: BELL, SIDNEY 202 KINLOCH, VICTOR 1284

St. Louis, Mo., July 27, 1922.

The Income and Disbursements for the Missouri Hospital Association,
Cash Receipts.

1.	Feb. 20.-Mrs. Atkins-Glenwood Sanatorium, Webster Groves, Mo.	$10.00
2.	Feb. 20.-Mr. H.North-Glenwood Sanatorium, Webster Groves, Mo.	10.00
3.	Mar. 4.-Miss S. Reitz-Andrian Hospital, Mexico, Mo.	10.00
4.	Mar. 20.-Dr. M. O. Biggs.-Supt. Hospital #1, Fulton, Mo.	10.00
5.	Mar. 20.-Dr. A. Van Ravensway-St. Joseph Hospital, Boonville, Mo.	10.00
6.	Mar. 20.-Brother Frumentius Horn-Alexian Bros. Hospital- St. Louis, Mo.	10.00
7.	Mar. 20.-Miss Isabell Baumhoff-Maternity Hospital- St. Louis, Mo.	5.00
8.	Mar. 20.-Dr. L. H. Burlingham-Barnes Hospital- St. Louis, Mo.	10.00
9.	Mar. 20.-Miss E. H. Bechtel-Burge Deaconess Hospital- Springfield, Mo.	10.00
10.	Mar. 20.-Mr. E. P. Howorth-Willows Maternity Sanitarium- Kansas City, Mo.	10.00
11.	Mar. 20.-Miss V. H. Nevison-Springfield Hospital- Springfield, Mo.	10.00
12.	Mar. 20.-Dr. F. E. Coil-Amanda Coil Hospital- Mexico, Mo.	10.00
13.	Mar. 20.-Miss H. Thomas-Amanda Coil Hospital- Mexico, Mo.	10.00
14.	Mar. 20.-Miss I. Baumhoff-Maternity Hospital- St. Louis, Mo.	5.00
15.	Apr. 11.-Mrs. L. Ament-Lutheran Hospital- St. Louis, Mo.	10.00
16.	Apr. 26.-Miss M. G. Burman-Childrens Mercy Hospital- Kansas City, Mo.	10.00
17.	Apr. 18.-Miss M. Rogers-Jewish Hospital- St. Louis, Mo.	10.00
18.	Apr. 19.-Dr. B. A. Wilkes-Missouri Baptist Sanitarium- St. Louis, Mo.	10.00
19.	June 5.-Dr. L. H. Wilson-Barnes Hospital- St. Louis, Mo.	10.00
20.	July 18.-Miss E. H. Wilson-Jewish Hospital- St. Louis, Mo.	10.00
	Total	$190.00

Lutheran Hospital
Potomac St. and Ohio Ave.

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Total $190.00

1922 ledger of hospital dues.

1965, President Lyndon B. Johnson signed Medicare and Medicaid into law.

Installation of Ham Reid as board chair at 1973 convention by Everett Johnson.

Ted O. Lloyd and James Kirkpatrick, Missouri Secretary of State.

Dr. Owens, Dr. Cashman and Neil Wortley, MHA board chair, at 1968 MHA convention.

Neil Wortley, 1977 MHA board chair, and Lester Cox, MHA board member.

Installation of 1972 MHA board chair, Sister Estelle Marie Vosen, by 1971 MHA board chair, Carl Virgien.

1976 ribbon cutting at St. Francis Mercy hospital.

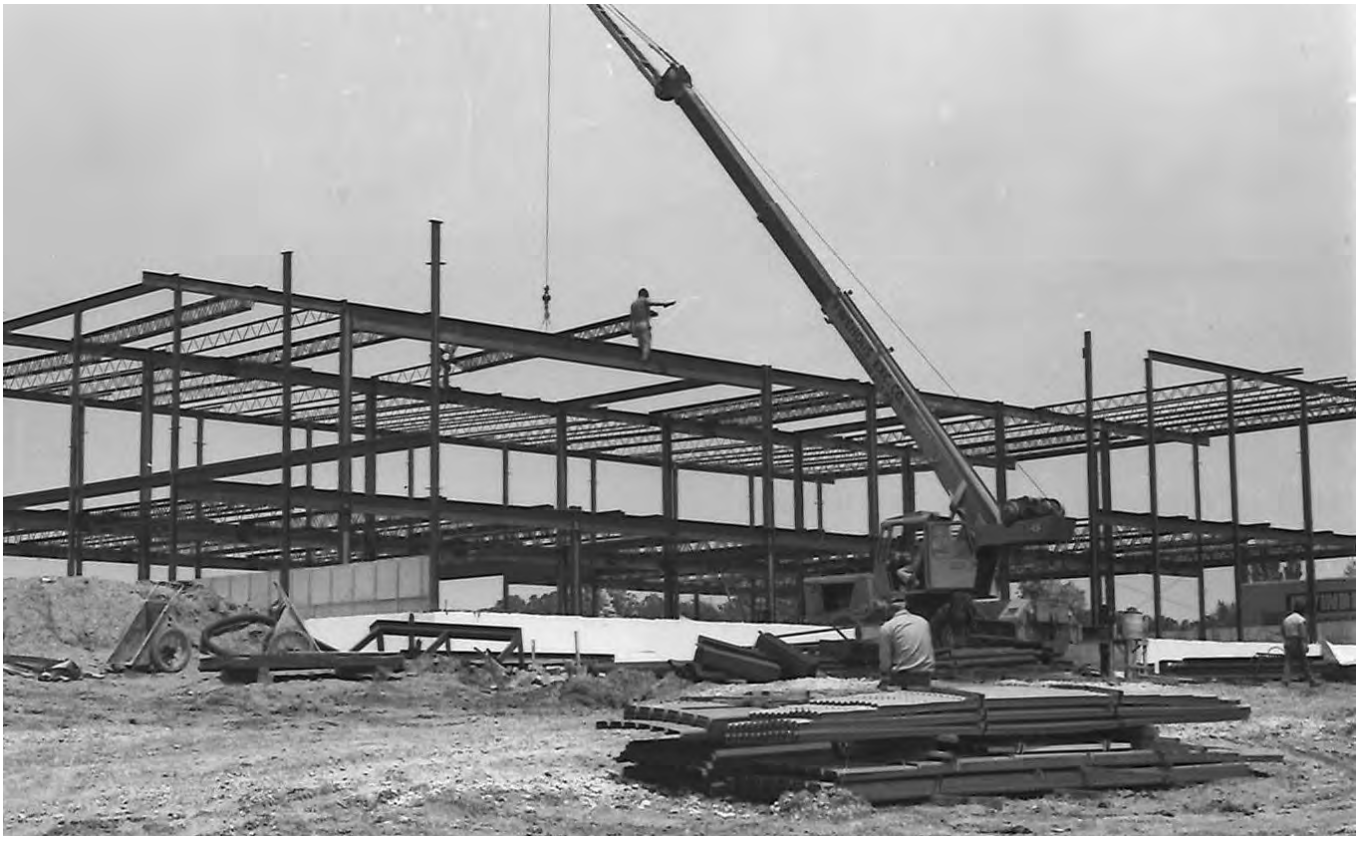
Catholic Sister comforting patient.

Candy stripers working with nurses, 1973.

Bill Warhurst, Missouri Health Data Corp., prior to Hospital Industry Data Institute.

MHA building groundbreaking.

C. Duane Dauner



1978-79 MHA building construction.

Charlie Bowman, Gov. Kit Bond and Dian Sprenger.

1992 Federal Reimbursement Allowance signing with Gov. John Ashcroft.

1995 Washington, D.C., meeting with Sen. John Ashcroft.

Gov. Mel Carnahan signs House Bill 564 to extend availability of health care to more than 600,000 Missourians through expansion of the Medicaid program.

MHA's first website release at the 1995 MHA convention.

MHA's first website on display at the 1995 MHA convention.

Charlie Bowman and Marc Smith at the 1997 MHA convention.

1998 MHA convention.

Tan-Tar-A, MHA convention headquarters.

Ken Kuebler

Marc Smith speaking at the annual MHA convention.

Gov. Jay Nixon signs the "prompt pay" act, 2009.

Medicaid Rally Day, 2013.

Washington, D.C., trip talking to Sen. Roy Blunt.

HIDI executives Theresa Roark (present) and Ken Kuebler (past) celebrate HIDI's 25th year in business.

MHA building expansion, 2014.

Herb B. Kuhn speaking at Gov. Parson's weekly press conference during the COVID-19 pandemic.

Herb B. Kuhn at the 2019 MHA convention.

Jon D. Doolittle at the 2019 MHA convention.

Jon D. Doolittle, President and CEO of MHA, 2021-present.

MHA front entrance.

MHA
100 YEARS OF HELPING HOSPITALS