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Hospital emergency rooms are overwhelmed these days. They’re often forced to turn away ambulances carrying the sick and the injured, directing them to another hospital. This is called “diversion,” and it is occurring in Little Rock and elsewhere throughout Arkansas. In fact, ER diversion has become a problem all throughout America. It is as important a public health issue as we have in this country, says Stuart Altman, economist and professor at Brandeis University who has also advised five American presidents on healthcare policy.

Overcrowded ERs and ambulance diversions—caused in great part by increased utilization and staff shortages—have been viewed with alarm by the healthcare community for some time. But now, the American public (and hopefully budget-cutters in Washington and the 50 state capitols) are becoming increasingly aware of the dilemma through programs like “Crisis in the ER,” which aired one recent night as a segment of CBS-TV’s 60 Minutes II.

The segment focused upon five-year-old Nicholas Carlson whose case of pneumonia took a turn for the worse. Paramedics worked furiously to save him as the ambulance raced to Riverside (Ohio) Methodist Hospital. When a paramedic called ahead to the ER, the hospital told him it was “on diversion.” The paramedic protested, saying the case was extremely serious, but was told to divert anyway. The ambulance then headed to Ohio State University Medical Center. As it was pulling into the OSUMC ER, Riverside called, saying it could now take Nicholas, but it was too late; the child was pronounced dead 20 minutes later.

During the 60 Minutes II interview, Dr. John Drstvensek, medical director of the Riverside ER, said that even though the ER was overwhelmed, a mistake had been made, that the diversion order should have been overridden. “It could have been done. And we urge the EMS and the nurses that if you have a patient in a critical condition, that they are just to go to the closest emergency department without fail.”

While network television cannot always be counted upon to be fair in its coverage of hospitals and medical issues, 60 Minutes II deserves credit for fairness. It noted that efforts to “cut out the fat” in healthcare have gone too far, forcing hospitals to close and putting more than 1,000 ERs out of business in the last 10 years. While the number of ERs has plummeted, the number of patients has grown. Along with an older and sicker population, many people who can’t get an appointment with their primary care physician end up going to the ER. Add to that the 43 million uninsured Americans whose main access to healthcare is through the ER, and you’ve got more than 100 million visits a year.

The result: most ERs are so overwhelmed they routinely turn away ambulances. Last year, the Johns Hopkins ER turned away ambulances 25% of the time. Cedars Sinai has seen its ER closed a full 35% of the time, and the Cleveland Clinic ER was on diversion nearly half of last year. All of this leaves paramedics who work the streets from Seattle to Little Rock to Miami struggling to find a place to take their patients.

Before ER diversion can be adequately addressed, it must be seen for what it is—yet another symptom of a stressed healthcare system. It will take all of us—hospitals, physicians, nurses, educators, insurers, and government—to heal the system. All of us must continue working to promote legislation to help attract and retain nurses, pharmacists, lab technicians, and other hospital workers. We must convince Congress to infuse “new” dollars into the system.

And, we must rid the system of burdensome regulations so that health professionals can care for patients instead of pushing paper. A recent survey found that healthcare workers complete one hour of paperwork for every hour spent providing patient care in hospital emergency rooms. This is not only unacceptable, it is outrageous.

James R. Teeter
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Little Rock pediatrician Dr. Joe Thompson, healthcare consultant Larry Walker, and AHA legal counsel Diane Mackey are among the featured presenters for the Arkansas Association of Hospital Trustees’ annual meeting scheduled for May 21 in Little Rock.

Dr. Thompson, pediatrician and preventive medicine specialist with the University of Arkansas for Medical Sciences and a population and policy analyst with the Arkansas Center for Health Improvement, will discuss a new approach to stabilize health insurance affordability in the state as well as measures to help some of the approximately 400,000 Arkansans with no coverage. One of the suggestions he will explore is to improve small employers’ ability to join together to buy coverage at lower rates.

Larry Walker, an Oregon hospital trustee and consultant to trustee organizations and the American Hospital Association, will focus on four aspects of governance: the driving forces of change shaping the future of healthcare; best practices for successful trustee leadership; development of a strategic board; and key performance indicators. Walker will also provide trustees with several “value added” pieces of information to share with fellow board members.

AHA legal counsel Diane Mackey of Friday, Eldredge and Clark in Little Rock, will focus on legal issues affecting hospital trustees, as well as potential legislation for the 2003 session of the Arkansas General Assembly.

Call Beth Ingram at 501-224-7878 for program information, or click on www.arkhospitals.org/calendar for a copy of the agenda.
Arkansas Newsmakers and Newcomers

Ben E. Owens, president of St. Bernards Healthcare in Jonesboro, has named Lee A. Simpson, Jr. as vice president of behavioral health services for St. Bernards and administrator of St. Bernards Behavioral Health Center. Simpson has 28 years of administrative experience in behavioral health and acute medical hospitals in Texas, Oklahoma and Tennessee.

Kurt Meyer, CEO of Delta Memorial Hospital in Dumas, has accepted the position of CEO of Rebsamen Medical Center in Jacksonville, effective April 8. He succeeds Tom Siemers who resigned effective March 28 to pursue business interests in Maine. Meyer began his career as an emergency room nurse in 1977. For the past 12 years he has worked in hospital management positions in Texas, Louisiana, and Dumas.

Ken Haynes, senior vice president and chief operating officer of St. Vincent Health System in Little Rock, also has responsibilities as administrator/CEO of St. Vincent Infirmary Medical Center. Prior to his association with St. Vincent Health System, Haynes was a senior executive with Baptist Memorial Hospital - Memphis.

John T. Hutton has been named Administrator/CEO for St. Vincent Medical Center/North in Sherwood. He will also continue as senior vice president of St. Vincent Health System with responsibilities for business development, clinic operations, and subsidiary operations. For the past fourteen years, Hutton was senior executive with Baptist Memorial Health Care Corporation in Memphis.

Ken Wood, CEO of Johnson Regional Medical Center in Clarksville since 1992, will retire March 22, 2002. Many major projects have been accomplished during Wood's tenure, including a new eight-bed ICU, a new physical therapy department, a new rehab unit, a new 5,000 square-foot freestanding administration building, three new clinics, and a medical staff that has doubled in numbers. Wood will continue living in Clarksville after retiring.

Darren Caldwell, CEO of Drew Memorial Hospital in Monticello, resigned January 18. He had served as CEO at the Monticello facility for the past five years, and will continue as a consultant assisting interim administrator Karen Donaldson until April 15.

Roy Wright, chief executive officer of Siloam Springs Memorial Hospital, resigned effective January 4, to accept a similar position at Stonewall Jackson Hospital in Lexington, Virginia.

David Laffoon, CHE, chief executive officer of Central Arkansas Hospital in Searcy, will retire May 31, after 27 years with CAH and Tenet Healthcare Corporation. Under his leadership, the hospital grew from a small medical-surgical hospital to a large specialty hospital. Laffoon is a past chairman of the Arkansas Hospital Association's board of directors on which he still serves representing the Arkansas State Board of Health.

Guy Hazlett II, FACHE, has been named administrator and CEO of Helena Regional Medical Center following the announcement that Community Health Systems, Inc. of Brentwood, Tennessee has leased the facility from the city of Helena. Hazlett has more than 30 years of experience in the healthcare field and is a former CEO of Woods Memorial Hospital in east Tennessee and Palo Pinto Hospital in north Texas.

James D. Baker, FACHE, has been named chief executive officer of Randolph County Medical Center in Pocahontas. He succeeds Michael Layfield who recently accepted an offer to serve as CEO of a Kentucky hospital. The Pocahontas facility is managed by Community Health Systems of Brentwood, Tennessee, which also operates hospitals in Newport and Helena.

Robyn A. Lynch, BS, CPC, CMSC, Director of Continuing Education at the Arkansas Pharmacists Association, recently passed a national certification examination for Medical Staff Coordinators. Certification establishes industry standards and serves as a comprehensive measure of knowledge for the medical services professional in the hospital/managed care setting. Robyn is an active member of the Arkansas Association of Medical Staff Services, an affiliate of the Arkansas Hospital Association.

Howard E. Campbell, 73, of Oklahoma City, Okla., died January 24. A graduate of the University of Oklahoma, Campbell was a retired hospital administrator, having served at Little River Memorial Hospital in Ashdown, Ark., and Hillcrest Hospital in Oklahoma City.
The Arkansas Hospital Administrators Forum/Arkansas Health Executives Forum summer management conference will be held June 12-14 at the Chateau on the Lake in Branson, Missouri.

Louise Probst, executive director of Gateway Purchasers for Health, an employer sponsored healthcare purchasing initiative serving the Greater St. Louis area, will discuss the Leapfrog Group’s recent regional rollout to implement safety practices that have proven to dramatically reduce the number of medical mistakes in hospitals. She will also discuss employer perspectives on the problems with healthcare quality.

Also on the program will be Connie Curran, president of Cardinal Health Consulting Services in Chicago, which provides unique services designed to help healthcare providers manage costs and quality in patient care. Dr. Curran will talk about the raging talent war, while focusing on intergenerational management, recruitment and retention. She will discuss approaches to redesigning patient care delivery, including the substitution of capital for labor, and the use of technology. In addition, Diane Mackey of Friday, Eldredge & Clark and AHA legal counsel, will present her always-popular annual legal update.

Along with the planned educational activities, Branson offers many opportunities for family entertainment—golfing, outlet malls, fishing, boating, swimming, tennis, a full range of musical entertainment for all ages and tastes, and much, much more—which make the trip to Branson memorable. Registration information will be mailed in a few weeks, but you are encouraged to make hotel reservations now. Call 1-888-333-5253 and mention the Arkansas Hospital Administrators Forum for reservations. Contact Beth Ingram at 501-224-7878 for additional information.

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Arkansas Bioterrorism Preparedness Funds

The State of Arkansas is due to receive a total $12.1 million in funding from the federal Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to help become more prepared for threats related to bioterrorism.

The state should receive about $2.42 million of the total—about 20% of the funds—soon, with the remainder to be available after the governor submits a comprehensive statewide plan for dealing with bioterrorism. The Arkansas Hospital Association has been working with officials of the Arkansas Department of Health to complete grants related to the initial distribution of the funds.

The bulk of the funding will come from the CDC, which will provide $10.8 million to help upgrade lab equipment and strengthen public health resources against infectious diseases and public health emergencies. Arkansas will receive about $1.28 million from the federal Health Resources and Services Administration (HRSA). The HRSA funds are intended to help state health departments, along with state hospital associations and others, develop a disaster readiness needs assessment to work toward a state plan of action in response to the identified needs.

Funds for the states were released by the Department of Health and Human Services January 25 and are part of an overall $1.1 billion in supplemental bioterrorism appropriations that President Bush signed into law in January.

Arkansas UPL Program Implemented

In July 2001, the federal Centers for Medicare & Medicaid Services approved a State Medicaid Plan amendment allowing Arkansas Medicaid to implement an upper payment limit (UPL) program. Under the plan amendment, Medicaid was permitted to make quarterly supplemental payments to hospitals under regulations governing the UPL programs that were placed into effect in January 2001. All of this would be accomplished without the use of additional state general revenues.

The initial supplemental payments were made in October 2001 to 41 hospitals in Arkansas categorized “non-state government” facilities. These hospitals are either owned and operated by a local governmental entity—i.e. a city or county—or owned by the local government unit and operated under a contractual arrangement by another organization. Governmental ownership allowed the hospitals to pay the state’s Medicaid match in order to draw down federal incremental payments. In Arkansas, the federal share of the payments amounted to 73% of the total.

Regulations in place allowed the “upper payment limit” for these non-state public hospitals to be 150% of the amount Medicare pays for similar services. Based on the 150% UPL, the 41 hospitals had the ability to tap into approximately $75 million dollars not previously available to them. After paying the Medicaid matching funds for the state and an administrative fee to the Medicaid program, the hospitals will net about $40 million annually in supplemental payments.

Other acute care hospitals in the state are classified as “private” facilities. They are able to share in a pool of about $10 million annually. The first batch of supplemental payments to the private facilities was paid in February 2002. Because rules prohibit the private hospitals from contributing the state Medicaid matching dollars to maximize their payments, their pool of supplemental payments is substantially less than the other hospitals and is based on state matching funds being contributed by the University of Arkansas for Medical Sciences.

In November 2001, CMS published a rule that will reduce the public hospital UPL to 100% of Medicare payments, rather than 150%. That rule was set to be effective March 19, barring judicial relief. The new limit, if implemented, will lower the amount of supplemental Medicaid payments for Arkansas’ non-state public hospitals to about $20 million, costing them 50% of the additional dollars originally available through the program.

[Editor’s note: In January, 2002, the federal Centers for Medicare and Medicaid Services published a rule that would decrease UPL funds coming to the state’s public hospitals by about $20 million annually. Several hospital groups and individual hospitals filed a lawsuit to block implementation of that rule in March. (See related article on page 31)]
THE ASBN UPDATE IS THE ONLY MAGAZINE THAT REACHES ALL 48,000 NURSES AND STUDENT NURSES IN ARKANSAS.

The Arkansas State Board of Nursing’s official publication The ASBN Update will have a brand new look beginning in June 2002. Formerly a newsletter, The ASBN Update will become a full-color, full-size glossy magazine with added editorial content. Designed and produced by Publishing Concepts, Inc., the same company who designs and produces Arkansas Hospitals, the publication is dedicated to promoting living and working in the great state of Arkansas. Articles featuring various hospitals and communities in Arkansas will appear in each issue to promote job opportunities and quality of life in those communities.

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Governor’s Mental Health Task Force

During the 2001 session of the Arkansas General Assembly, there was much discussion and little action regarding the problems of the state’s public mental health system. It was noted that community access to public mental healthcare services is lacking, the Arkansas State Hospital (ASH) has an insufficient number of acute care beds to meet public needs, mentally ill persons are being warehoused in jails awaiting treatment and/or evaluation at the Arkansas State Hospital, Community Mental Health Centers are inadequately funded to meet the mental health needs of the communities they serve; and hospitals are financially burdened by the growing levels of unreimbursed care provided to indigent mentally ill adults.

Recognizing these problems, Governor Mike Huckabee established the Governor’s Mental Health Task Force and charged it with making a thorough study of the state’s public mental health system and recommending solutions in May 2002. The Arkansas Hospital Association serves on the task force and one of its principal work groups dealing with acute mental healthcare issues.

The Acute Care Work Group has found that many of the problems in the public mental health system are directly attributable to a shortage of acute care beds at ASH. It also found that approximately half of the 90 acute care beds at ASH have been diverted to other than acute care needs. Hospitals seeking to transfer indigent mentally ill patients to ASH are finding it difficult if not impossible to make those transfers due to the lack of beds.

As a result, patients are unable to get the care they need and hospitals are experiencing substantial increases in the level of unreimbursed care provided to the indigent mentally ill since there is no public system in place to reimburse hospitals for inpatient services provided to this population. The shortage of acute care beds at ASH also causes mentally ill persons to be warehoused in jails while awaiting transfer to ASH for treatment and/or evaluation.

Arkansas Insurer Gets Medicare Contract

Arkansas Blue Cross and Blue Shield (ABCBS) has been selected by the federal Centers for Medicare & Medicaid Services (CMS) to be the nation’s single Part A maintenance contractor for Medicare’s Fiscal Intermediary Standard System (FISS), the primary component of Medicare’s claim processing function under Medicare Part A. The new contract became effective February 13. There will be a six-month transition period, during which all functions will shift from the current contractor, First Coast Service Options, located in Florida, to ABCBS.

The contract gives ABCBS responsibility for providing computer software services to support FISS, including maintenance, development enhancements and special projects. In addition, the Arkansas insurer will be responsible for maintaining and improving the FISS software, and with distributing the software to seven regional data centers which process Medicare claims.

With the contract, Arkansas Blue Cross becomes the sole national “maintainer” of the computer software system used to process more than 160 million Medicare Part A claims nationwide. The potential five-year contract will require the creation of approximately 100 new jobs, including full-time and/or contract employees needed to support the system. Most of the new jobs will be located in Arkansas.

ABCBS currently administers Medicare Part A and Part B programs in Arkansas and also administers Part B claims in Louisiana, Oklahoma, New Mexico, and eastern Missouri. As of Dec. 31, 2001, Arkansas Blue Cross serves 2,524,613 Medicare beneficiaries in five states and processes more than 42 million claims annually, with a payout totaling more than $3.8 billion. The company also serves as the Data Center for contractors who process Medicare Part A claims for Alabama, Alaska, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, North Carolina, Rhode Island, and Washington.

Arkansas Hospital Association’s Board of Directors has approved membership applications for two facilities: Regional Medical Center at Memphis, which is a 620-bed acute care facility. Bruce Steinhauer, M.D. is the president and CEO.

Living Hope Texarkana, a 62-bed inpatient psychiatric facility. Kimbro Stephens is president and CEO.
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Nature has never been shy when it comes to posing for artists. From breath-taking landscapes to mighty animals, natural subjects have always inspired great art.
much more user-friendly,” explains Mike Senske, owner of Aquarium Design Group in Houston.

Like their traditional art counterparts, aquarium owners creating living art have plenty to choose from when searching for the right aquatic setup for a room. Freshwater aquariums, saltwater aquariums and living coral reefs are definitely in vogue. Even non-marine alternatives offer startlingly beautiful alternatives. Terrariums, for example, can bring exotic rain forest plants or bright tropical flowers into the center of a home.

The right aquarium can begin with anything from a simple tank to a dramatically designed marine lifescape accented by inventive lighting and daring wood walls. When it comes to containers for a home’s new marine centerpiece, it’s often important to think outside the box, literally. The traditional rectangular “frame” of an aquarium can easily be replaced with a cylindrical aquarium or a tall, floor-to-ceiling display unit.

The placement of an aquarium can be as individual as each homeowner. Living art aquariums can stand on their own atop a stand or mimic the placement of traditional art through an inset in a wall. Senske recommends asking yourself some questions before settling on a space: In what part of the home do you spend the most time? Does the potential aquarium site receive a lot of direct sunlight? Is there enough room for equipment, particularly for saltwater aquariums?

Some interior designers incorporate marine environments into functional elements of a room. A wall that divides the kitchen from the family room, for example, can be a perfect location for an aquarium. Setting an aquarium in the wall between the two rooms allows light to filter between the spaces, while the animated marine residents reflect the active lives within the adjoining rooms. Drafting an aquarium into the blueprints for a bathroom renovation can give a dynamic aquatic emphasis to the new space.

What price living art? Though the going rate for a van Gogh may be too steep for anyone who’s last name isn’t Rockefeller, a precious piece of aquarium-based marine art is well within just about anyone’s budget.

The best place to start any quest for the perfect aquarium may be with designers who specialize in crafting aquatic landscapes for the home. Like a traditional museum or art gallery, some marine environment design groups give potential clients the chance to view their works up close. The Aquarium Design Group, for example, boasts its own gallery of aquascapes.

Unlike a painting or sculpture, an aquarium does require a bit more maintenance than an occasional dusting. “You have to remember to budget for the long-term commitment of servicing a living piece of artwork,” Senske cautions.

Not all aquariums come with similar maintenance needs. A saltwater living reef setup will require a far more hands-on
maintenance approach than a freshwater aquarium with artificial plants. Some aquariums will need weekly service, while others can get by with only monthly attention. No matter the frequency of the maintenance schedule, Senske adds, consistency in service is crucial.

For those who are afraid of a showcase aquarium’s need for regular nurturing, some designers offer no-hassle maintenance arrangements. For a fee, companies will keep aquariums and their swimming residents in good health, checking the care and feeding needs of the aquatic art’s animal subjects and keeping life support systems in working order. Some firms even offer computer-monitored systems that page the central office if anything’s amiss in a home’s display aquarium.

Check some credentials, however, before signing an aquarium maintenance deal with any company. Guaranteed work is good, but be sure a design group has experienced staff with plenty of marine biology know-how. Look when possible for firms that can respond to any aquarium emergency situation 24 hours a day.

Interested in bringing the living art of an aquarium into your living room? Consider the design tips offered at the following companies and Web sites:

- **Aquarium Design Group**, www.aquariumdesigngroup.com
- **Dive In! Aquarium Fish**, www.diveintofish.com
- **Tropical Décor**, www.tropicaldecor.com
- **Aquarium Design**, www.aquarium-design.com
- **Aquatic Design Systems**, www.aqds.com

*This custom 200 gallon aquarium can be viewed from 2 different rooms in the home: the study and the bar area. Photo provided courtesy of Oceanic Systems, Inc. and Aquarium Environments*
Most people would never describe themselves as lifesavers. Yet many have chosen to be — and many more could be. Saving a life can be as simple as making the decision to become an organ donor.

Every day in America, 60 people’s lives are prolonged thanks to a desperately needed organ donation. But 15 people on the waiting list die each day because there still aren’t enough organs available to save them.

A single individual’s decision to donate organs or tissues can prolong dozens of other lives. Up to 50 people can benefit from just one person’s gift. Consider the impact of one individual’s donations. A heart and lungs can each be used by others, while the donation of kidneys can spare two people from dialysis. A single pancreas can also keep two individuals off dialysis. Donating a liver can be a lifesaving gift to two people waiting for transplants. Corneas, bones, bone marrow, skin and even a portion of an intestine can make the difference between life and death for others.

Becoming an organ donor is a relatively simple process. Most make their wish to be an organ or tissue donor known when applying for a driver’s license. Some make their decision to donate part of their legal will. Signing an organ donor card and keeping it with you is a great way to make your decision count.

Perhaps the most important guarantee that your decision to donate will be honored, however, is to discuss it with family and friends. A donor card or a request recorded in your will may be uncovered too late for medical professionals to recover organs and pass your gift of life on to someone else. And families often must sign a consent form before donation can occur. “Time is of the essence,” so please make sure your loved ones are all aware of your wishes.

Just about anyone can become an organ donor, young or old, vigorously healthy or not. Everyone from senior citizens to newborn babies has given the gift of life. However, those under 18 years of age must have a parent’s or guardian’s permission. Even histories of medical illness are not necessarily barriers to organ donation. Decisions regarding the medical suitability of a person’s donation aren’t made until the time of death.

Organ donation isn’t an all-or-nothing proposition. Those who only want to donate a few particular organs can specify their wishes and be certain those requests will be honored after their deaths.

For a closer look at what it takes to become a lifesaver, visit the federal government’s organ donation Web site at www.organdonor.gov.
Three Little Rock healthcare institutions learned recently that they will share a $9 million gift from the estate of an Ashley County family. Arkansas Children’s Hospital, Baptist Health, and Central Arkansas Radiation Therapy Institute (CARTI) will each receive $3 million of the donation.

Mary Ann Boyd, a former nurse at Baptist Medical Center–Little Rock, who died in November, donated the money as part of her will. Boyd was the last surviving daughter of John and Monitte Boyd of Fountain Hill. Her father operated the Boyd & Nichols General Store in the south Arkansas town for 32 years, before his death in 1986. Although he died from a heart attack, he also had been diagnosed with prostate cancer and was undergoing treatment at CARTI.

Ms. Boyd had been a nurse in the cardiac unit at the Little Rock medical center from 1978-1985, and was treated as a patient there before her death. A sister, Carolyn, had been born mentally challenged and lived many years at the Arkansas Children’s Colony in Conway. She died at age 29 in 1985.

During a ceremony announcing the donations, CARTI officials said its share of the gift will be used to upgrade equipment and complete remodeling of the CARTI facility located on the campus of St. Vincent Health System. That will be renamed the John Boyd Family Pavilion.

Children’s Hospital plans to create two endowments. One will be the John Boyd Family Endowment in pediatric nursing, which will include an endowed chair in nursing in collaboration with the University of Arkansas for Medical Sciences’ School of Nursing. ACH will use the other part of its donation for an endowment in the hospital’s child-life and education program, which trains child-life specialists who help children and parents deal with major illnesses or injuries.

At Baptist Health, the funds will go toward improvements in heart services provided in the same unit where Mary Ann Boyd worked between 1978 and 1985.

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AHA/AMS Anesthesiology Task Force Formed

A joint task force of the Arkansas Hospital Association and the Arkansas Medical Society has been formed to resolve some common concerns which could affect the current and future availability of anesthesia services in Arkansas. In its most recent meeting, the task force reviewed survey information collected late last year from hospitals and physician anesthesiologists. The information confirmed that there is a problem throughout Arkansas of obtaining and retaining anesthesiologists as well as certified registered nurse anesthetists (CRNAs).

The survey also reflected that there are numerous openings for anesthesiologists and CRNAs in hospitals located in every area of the state and that anesthesia providers receive frequent offers to go out of state or move from one community to another within Arkansas. Hospitals trying to recruit new anesthesiologists or CRNAs can expect to wait up to 18 months before seeing results.

The joint task force began working together last fall and was successful in securing a fee increase for services provided Arkansas Blue Cross and Blue Shield patients. The insurer announced last October that it would boost the fees from $34 per unit to $42.

However, low Medicare reimbursement for anesthesia services for Arkansas providers remains a concern. While the Arkansas congressional delegation seems to support increased Medicare reimbursement, the task force agreed it is unlikely any increase will occur this year.

The task force also discussed efforts by Arkansas State University to develop and implement a CRNA school there. Many hospitals in Arkansas have voiced their support of the school, which would allow for an increase in the supply of CRNAs available to them. At the same time, the University of Arkansas for Medical Sciences is working to increase its number of graduating anesthesiologists.

Study Details Arkansas Insurance Coverage

A new study on insurance coverage in the state—or the lack of it—shows that 400,000 Arkansans have no health insurance. That represents about 15% of the total population and includes 20% of all working-age adults. The study was conducted in 2001 by the Arkansas Center for Health Improvement (ACHI) and is the first comprehensive study of health insurance coverage among the state’s residents to be completed.

The study was performed as part of a federally funded effort to determine states’ health insurance needs. ACHI researchers, led by Dr. Joe Thompson, an Arkansas Children’s Hospital pediatrician, plan to join state officials in March to present a plan addressing the state’s critical needs to the federal Department of Health and Human Services. From there, the plan will go to Congress, which is scheduled to examine needs of the eleven states participating in the assessment program, along with their recommended actions, next summer.

The ACHI report includes suggestions to stabilize health insurance affordability as well as measures to help those with no coverage. Among the suggestions: improve small employers’ ability to join together to buy coverage at lower rates, support of further outreach and enrollment efforts for the ARKids First Children’s Health Insurance Program, and development of a safety-net insurance program that would provide for a minimal benefits package for low-income uninsured adults.

EMTALALA Advice Regarding Violent Patients

The Dallas Regional Office of the Centers for Medicare & Medicaid Services (CMS) recently provided the Arkansas Department of Health with an update of information regarding requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA) as they relate to admission or transfer of violent patients.

The specific issue involves whether an acute care hospital that has a distinct-part psychiatric unit may refuse to admit violent patients (as defined under strict criteria) because it doesn’t have the capability to handle them.

The advice was given in response to concerns about situations where potentially dangerous incidents have occurred in hospitals which do not have the physical configuration or the staff to handle a violent patient. In some cases, a hospital may be reluctant to use restraint and seclusion, even on violent patients, due to CMS’ patient rights standard, especially if it has received an adverse determination about the use of restraints in a past survey.

In such cases the hospital may prefer to treat and stabilize, then transfer violent patients that meet the criteria for exclusion. The question was raised whether CMS would consider such a practice an EMTALA violation or a discriminatory action.

According to Dodjie Guioa of the Dallas office, capacity to render care is not simply reflected by the number of staff on duty or the amount of equipment on the hospital’s premises. Rather, it includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits (e.g., moving patients to other units, calling in additional staff, and borrowing equipment from other facilities).

“Capabilities” means that there is a physical space, equipment, supplies, and services that the hospital provides. It also encompasses the level of care that the staff can provide within the training and scope of their professional licenses.

A hospital will be deemed to have met its EMTALA obligation only in cases where it does not have the capacity or the capability to care for the patient and its handling of the patient is consistent with that done for any and all patients meeting the exclusion criteria and set forth in a policy approved by the hospital board. Requests to transfer a “violent patient” can also be dealt with in the same manner.
Arkansas Legislative Nursing Commission Update

The Arkansas Legislative Nursing Commission, which was created by the Arkansas General Assembly during its 2001 session, has been meeting monthly since last September, gathering data and hearing testimony about the depth and severity of the state’s acute shortage of Registered Nurses.

That process included testimony in December by hospital chief executive officers Bob Bash (Booneville Community Hospital), Bob Atkinson (Jefferson Regional Medical Center in Pine Bluff), Ross Hooper (Crittenden Memorial Hospital in West Memphis), and John Robbins (Conway Regional Medical Center), who discussed ways they and their hospitals are dealing with the issue.

During its most recent meeting, February 11, the commission moved to another phase of its task and began reviewing specific recommendations for easing the shortage. They included one by the Arkansas Hospital Association (AHA), which encouraged the commission to concentrate on increasing the supply of nurses and to resist efforts to impose additional costly and unnecessary regulations on hospitals.

Among other things, the AHA recommended support and encouragement for early recruitment of students into nursing as well as a more concentrated effort to recruit more males and minorities into nursing and legislation to fund more scholarships, grants, loans, and loan forgiveness programs for nursing students.

The Arkansas Nurses Association (ArNA) wants the commission to impose statutory restrictions on mandatory and voluntary overtimes and establish staffing standards consistent with recommendations of the American Nurses Association. The nurse organization also is pushing for improved salaries, programs to improve the image of nursing as a career choice and profession, and promotion of the Magnet Nursing Services Recognition Program.

The commission is charged with studying the nursing shortage and recommending solutions to the 2003 Arkansas General Assembly. State Senator Brenda Gullett of Pine Bluff chairs the commission. In addition to the AHA, the commission is comprised of members of the legislature, representatives from the Arkansas Medical Society, the Arkansas Health Care Association, various nursing organizations, and consumers. The final report is due in November 2002.

J&J Funding Recruiting Effort

In perhaps the first supplier-led effort to ease a nationwide nursing shortage, Johnson & Johnson (J&J) announced a $20 million, two-year campaign to recruit more people to nursing in hospitals and extended care facilities, where an acute shortage is expected to triple in coming years.

The campaign, called “The Campaign for Nursing’s Future,” offers scholarships and nationally televised advertisements, which began airing during coverage of the Winter Olympics.

In addition, the campaign will include recruitment brochures, posters, and videos for high schools, nursing schools, and nursing organizations; scholarships for students and nursing faculty; a multi-city scholarship fundraising effort with hospitals, nursing organizations and hospital associations; and a Web site, www.discovernursing.com, about the benefits of a nursing career featuring searchable links to hundreds of nursing scholarships and more than 1,000 accredited nursing educational programs.

The campaign will expand in the future to address other areas affecting the nursing profession, including ways to retain nurses in hospitals. According to J&J, the nation’s hospitals are short 126,000 registered nurses, and nurse vacancies are expected to increase to more than 400,000 in all healthcare facilities by 2020.

Arkansas 2001 PAC Contributions

During 2001, the Arkansas Hospital Association Political Action Committee (AHAPAC) received $22,784.15 in contributions, primarily from hospital executives and employees throughout the state. These donations make possible the support which the Arkansas Hospital Association and the American Hospital Association are able to provide to political candidates seeking state or federal elective offices.

Contributions of any amount from all contributors to the AHAPAC are seriously needed and deeply appreciated. However, special acknowledgement is given individuals who contribute at certain threshold levels. Those individuals qualify for recognition as members of the Arkansas and the American Hospital Association’s Capitol Club or American’s Chairman’s Circle.

A $250 donation, which helps fund the political action committees of both organizations, merits recognition as a member of the Capitol Club. The Chairman’s Circle membership is earned with a $500 donation.
EMTALA Revisited?

As he promised last summer, HHS Secretary Tommy Thompson has begun plans to revisit the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to screen, stabilize, or transfer patients seeking emergency treatment without regard to their financial status. The law prohibits hospitals from dumping patients at other hospitals or failing to treat patients for economic reasons.

Tom Scully, administrator of the Centers for Medicare and Medicaid Services, vowed to take action by June to revise the law, saying it is rife with problems for providers, lacks clarity and is inconsistently interpreted, leaving providers confused and uncertain. He has hired William Rogers, M.D., an emergency medicine specialist and director of the emergency department at Winchester (VA) Medical Center, to advise the CMS on this topic.

Rogers believes there is room for greater flexibility to accommodate innovation, saying that multi-hospital systems should be able to shuttle non-critical ER patients who are obviously stable and seeking minor treatment from a crowded ER to a different hospital within their system to treat them faster and better. The current EMTALA law requires a full screening and medical exam.

HHS’ new Advisory Committee on Regulatory Reform held its first public regional hearing in Miami in late February where members heard testimony from patients, emergency department staff, EMS personnel, hospital administrators and on-call physicians. Jody Lehman, corporate vice president for Baptist Health South Florida, recommended adapting screening regulations to differentiate between critical and non-critical patients.

Lehman said such a new rule would allow caregivers to provide other options to non-critical patients during times of severe emergency department overcrowding, while still complying with the law.

Alzheimer’s Disease Caregiver Guide

The National Institute on Aging and the Alzheimer’s Disease Education & Referral (ADEAR) Center have made available a free publication for family and other home caregivers of people with Alzheimer’s Disease (AD). The Caregiver Guide is a handy 28-page booklet filled with tips, resources, and support, based on up-to-date AD caregiver research from Duke University and Johns Hopkins University Alzheimer’s Disease Centers.

The Caregiver Guide offers practical tips for daily coping with bathing, dressing and eating; activities and exercise; incontinence; sleep problems; hallucinations; wandering and home safety; driving; and choosing a nursing home.

To order a free copy, call 1-800-438-4380 or download the booklet from www.alzheimers.org/pubs.careguide.htm.

Medicare Payment Error Rate Continues to Decline

The Centers for Medicare and Medicaid Services’ (CMS) efforts to monitor payment error rates and develop appropriate corrective action plans seems to be paying off, even though it improperly paid an estimated $12.1 billion in processed fee-for-service payments in fiscal year (FY) 2001. These improper payments range from reimbursement for services that were provided, but inadequately documented, to inadvertent mistakes, to outright fraud and abuse, says a recent audit report from the Office of Inspector General (OIG).

The current error rate of 6.3% is less than half of the 13.8% error rate the OIG found in FY 1996. However, the OIG cannot conclude whether it is statistically different from the previous three years’ estimates, which ranged from 6.8% to 8%.

Go to http://www.OIG.hhs.gov/oas/reports/cms/a0102002.pdf to read the audit report “Improper Fiscal Year 2001 Medicare Fee-for-Service Payments.”

National Hospital Week, May 12-18

All Arkansas hospitals should have received a copy of the American Hospital Association’s (AHA) planning guide and catalogue for National Hospital Week (NHW), which will be celebrated May 12-18. This year’s theme is “Where Miracles Happen Every Day.” Packets containing the guides were sent to CEOs, administrators, PR and marketing staff in hospitals and others who have expressed an interest in the hospital week information over the years.

The AHA is continuing its marketing agreement with HealthShare/THA, a subsidiary of the Texas Hospital Association (THA), for development of materials, the mailing of packets and fulfillment of requests for materials. Questions about the packets should be directed to the customer service representative for THA’s vendor, Bell’s International, at 1-800-822-1923.

To access National Hospital Week material online, go to www.aha.org and click on the “NHW” icon. It is among the flashing icons that rotate on the home page. Download the catalogue and planning guide directly from the Web site.
Many people have trouble functioning well as patients, even health professionals. Whether limited by knowledge, socioeconomic factors, emotional or clinical state, or cultural background, their level of health literacy—the ability to read, understand, and act on healthcare information—is often dangerously low.

According to the Institute for Safe Medication Practices, one example of this problem is when using “once” on prescription directions for a Spanish-speaking patient. In Spanish, “once” means “eleven,” which could result in a serious error when taking oral medications. Unless one speaks and writes in another language fluently, or has an interpreter, software or another means to translate labels accurately, translating prescription instructions should not be attempted. Hospitals and pharmacies might consider having patient information brochures for the most common medications already translated into that language.

Other examples of patients who’ve had difficulty reading and understanding medication directions are plentiful. The elderly patient who couldn’t tell if he’d picked up his bottle of COUMADIN (warfarin) or CELEBREX (celecoxib). Young mothers who, after reading the acetaminophen label, couldn’t accurately state their child’s dose. Teenagers who’ve misunderstood directions for contraceptive jelly and have eaten it on toast every morning to prevent pregnancy.

Poor health literacy is not an isolated problem with the elderly, disabled, uneducated, or certain socioeconomic classes, as these startling facts from AMA’s Health Literacy Introductory Kit prove:

- More than 40% of patients with chronic illnesses are functionally illiterate.
- Almost a quarter of all adult Americans read at or below a 5th grade level while medical information leaflets are typically written at a 10th grade reading level or above.
- An estimated three out of four patients throw out the medication leaflet stapled to the prescription bag without reading it.
- Only half of all patients take their medications as directed.
- Low health literacy skills have increased our annual healthcare expenditures by $73 billion.

Furthermore, people who have difficulty reading or understanding health information are ashamed and often hide the problem. In addition, low literacy isn’t obvious. Researchers have reported poor reading skills in some of the most poised and articulate patients.

Assume Every Patient Has a Literacy Problem

A new report released by the American Hospital Association (AHA) and three other hospital advocacy groups shows the healthcare workforce shortage in the U.S. is severe and getting worse. The report, produced by First Consulting Group is based on 2001 survey data. It gives an up-to-date picture of what hospitals are experiencing and provides a comprehensive look at the numbers and implications of the workforce shortage.

The survey data showed that a severe shortage of healthcare workers exists, with vacancy rates (the number of budgeted but unfilled positions) for registered nurses, pharmacists, and imaging radiology technicians averaging 10% nationwide. More than one in seven hospitals report a severe shortage of nurses, with more than 20% of RN positions vacant.

Among other key findings:
- The situation is getting worse: According to 60% of hospitals, the recruitment of nurses has become even more difficult in the last two years and demand for all positions is increasing.
- Hospitals are striving to fill these positions and costs are increasing: 56% of hospitals are using agency or traveling nurses to fill vacancies and 41% are paying sign-on bonuses.
- A shortage of personnel is affecting access to care: Hospital workforce shortages contribute to emergency department overcrowding and diversions.

Other sponsoring groups include the Association of American Medical Colleges (AAMC), the Federation of American Hospitals (FAH), and the National Association of Public Hospitals and Health Systems (NAPH). Copies of the report are available online at the AAMC, AHA, FAH, or NAPH Web sites.

Report Shows Workforce Shortage Effects

AHRQ Tip Sheets Help Consumers Avoid Medical Errors

The Department of Health and Human Services’ Agency for Healthcare Research and Quality recently announced new consumer tip sheets in English and Spanish to help Americans avoid falling victim to medical errors. AHRQ said its tip sheets arm citizens with advice on how to reduce the likelihood of having a mistake occur. They do that by explaining, through illustrations and easy-to-understand text, five ways to avert such problems.

Medical errors include patients being given the wrong type or dose of prescription medicines, having surgery on the wrong part of the body and contracting an infection within a hospital. AHRQ said that medical errors cause between 44,000 and 98,000 deaths annually in hospitals alone, and cost the nation $29 billion in added health care costs. For more, go to http://www.ahrq.gov.
Healthcare Access Is Bush Priority

During comments before the Medical College of Wisconsin in Milwaukee February 11, President Bush outlined his long-range health agenda, which places heavy emphasis on making healthcare more accessible and affordable. His proposals would be carried out over a 10-year period at a cost of $300 billion, not including the $190 billion requested in the administration’s FY 2003 budget for overhauling the Medicare program and adding a prescription drug benefit.

Items on the President’s priority list include $14 billion to expand tax-free medical savings accounts, $15 billion to subsidize 60% of health premium costs for the recently uninsured, and an $89 billion plan to introduce $1,000 tax credits for individuals and $3,000 for families. Bush also called for the creation of association health plans in which small employers could form insurance-coverage purchasing pools and addition of 1,200 community clinics throughout the U.S. over the next five years.

Bush’s comments concur with the states’ priorities for healthcare changes. According to a “State of the States” report released February 14 by the Blue Cross and Blue Shield Association (BCBSA), expanding access to care, including coverage for the uninsured, and affordable prescription drug coverage is a top healthcare priority in 20 state legislatures this year. The report indicates that both are expected to be contentious issues in most states. To view the report in its entirety, visit www.bcbshealthissues.com/state.

The access issue is already the subject of a major effort in Arkansas, where the Arkansas Center for Health Improvement (ACHI) is preparing a plan addressing the state’s critical coverage needs. The ACHI plan—to be reviewed by officials in Washington next summer—includes suggestions to stabilize health insurance affordability as well as measures to help those with no coverage.

APC Rate And Codes Changes

The December 31, 2001 Federal Register contained revisions to the Medicare outpatient prospective payment system (OPPS) rule, including changes in Medicare co-insurance amounts for more than 50 outpatient ambulatory payment classifications (APCs).

The revised rule, which will mean significant rate changes that hospitals should prepare for, was to have been effective January 1, 2002, but the effective date was delayed until at least April 1, 2002. The 2001 APC payment rates and Intermediary claims processing systems are continuing until that effective date.

Subject to further modifications by the Centers for Medicare & Medicaid Services (CMS), some APCs will see payment increases over 100%. One example is APC 108 for pacemakers, which will increase 175%. However, more than 240 other APCs are projected to have rate cuts, with more than 60 of the cuts greater than 25%. Plus, there are more than 80 new APCs expected for 2002 and several existing APCs that will be dropped or replaced with new APCs.

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- An excellent staff representing your best interests.
New Telephone Scam Extremely Costly

Hospitals and their employees should be aware of yet another telephone scam that has been identified by the National Fraud Information Center. The scam is spreading quickly and can easily cost victims $2,400 or more. The communications company Verizon first brought the scam to national attention and cautions that people should not respond to emails, phone calls, or web pages which instruct targets to call “809,” “284,” or “876” area codes.

There are lots of different permutations of this scam, but, in general, here’s how it works: A message is left on an answering machine or pager, asking the person at that listing to call a number beginning with one of the area codes. The reason for the call varies. It may relate to an emergency situation or information about a prize of some sort, etc. The person receiving the call is told to call the phone number right away.

If the returned call originates from the U.S., there will be a $2,425 per-minute charge. The call could connect to a lengthy recorded message intended to keep the caller on the phone as long as possible to increase the charges. Unfortunately, bills often can amount to more than $24,100.

The area codes are located in the Caribbean. They can be used as a “pay-per-call” number, similar to 900 numbers in this country. Since none are U.S. area codes, they are not covered by U.S. regulations of 900 numbers, which require that you be notified and warned of charges and rates involved when you call a “pay-per-call” number.

There is also no requirement that the company provide a time period during which you may terminate the call without being charged. Further, while many U.S. homes have their phone carriers block calls to 900 numbers to avoid the related charges, the blocks do not work in preventing calls to the foreign area codes.

Persons receiving messages to return calls to a number having one of the area codes should disregard the message. Trying to fight the charges afterwards can become a nightmare, because a call was actually placed. Local phone companies and long distance carriers probably won’t get involved, opting to let victims deal with the foreign companies on their own.

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Call it the earliest weapon of mass destruction. With a blinding flash and scorching heat, a single bolt of lightning could leave a zone of ruin so complete that the ancient Greeks imagined its source could only be divine. The terrifying thunderbolt of Zeus helped him earn top billing in the Greeks’ pantheon of gods.

Humans both ancient and modern had good reason to fear lightning: Each bolt packs a stunning 1 billion-volt electrical punch, enough juice to keep a 100-watt light bulb burning bright for three straight months. Displays of such awesome power aren’t rarities, either. Every second in America, lightning strikes 100 times. That’s about 8 million direct hits each day.
As an invisible negative charge begins to flow from the cloud toward the ground, it pulls a positive charge up from the ground, often through a tall object such as a tree. When the two charges meet, a powerful electric current, the return stroke, springs to life. Though lasting only a fraction of a second, that 1 billion-volt return stroke creates a blinding flash, as well as temperatures soaring above a scorching 50,000 degrees Fahrenheit. The resulting shock wave hits nearby ears as thunder.

**Losing the Lightning Lottery**

Daredevil humans such as Ben Franklin have certainly tempted fate and survived while toying with heaven’s electrical fire. But for many people who find themselves in the path of lightning, the results can be devastating. Most estimates of the number of people in the United States killed every year by lightning range between 80 and 100. That puts lightning second only to floods on the list of the nation’s top weather-related killers.

The majority of thunderbolt targets survive their experience. About 1,000 Americans are injured by lightning every year, experts say, with most suffering only indirect hits. While both genders may be equal in the eyes of the law, Mother Nature has a definite bias against the males of the human species: More than 80% of those struck by lightning are men.

A lightning strike can wreak years of havoc on the victims who survive its wrath. Cardiac arrest is the cause of death for those killed by lightning. But those who live can suffer from burns (often caused not by lightning, but by water or metal objects on the victim) and disabling nerve injuries causing intense headaches, dizziness, seizures and chronic pain. The physical and psychological effects can sometimes last decades.

The old saying that you have a better chance of being struck by lightning than of walking away with a winning lottery ticket is usually true. The odds of being on the wrong end of a lightning bolt during a year are about 600,000 to one.

Those odds can vary greatly, however, literally depending on where you’re standing and when. When it comes to lightning, geography can be destiny. A man standing in typically thunderstorm-free western Oregon is probably in far less danger of becoming a human lightning rod than the guy living in the electrically active corridor between Tampa Bay, Fla., and Lakeland, Fla. In fact, the Sunshine State is the nation’s favorite bull’s-eye for cloud-to-ground lightning strikes, with some sections averaging nine or more lightning strikes annually per square kilometer.

When it comes to lightning injuries, timing, too, can be everything. Ninety percent of lightning-related deaths occur between May and September, when thunderstorms are at their rowdiest.

Some favorite American pastimes can increase the odds that a lightning storm will prove lethal. The link between golf and lightning strikes is justly infamous. Professional golfing great Lee Trevino nearly had his career and his life abruptly ended during a freak lightning strike at the 1975 Western Open.

Most experts agree that much of the danger inherent in golf springs from golf course design, which emphasizes plenty of open areas with small groups of trees scattered throughout. That makes it much more likely that a golfer will suddenly find herself the highest point in a wide area during a thunderstorm. Lightning also has a special attraction to metal golf clubs and umbrellas, particularly in the

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*With metal clubs, wide open areas, and lots of trees, golf courses can be very dangerous during a lightning storm.*
hands of golfers standing out in the open on fairways or putting greens. Today, even the sport’s major professional championships quickly come to a halt whenever a chance of lightning moves over a golf course. Many golf clubs use sirens or air horns to keep golfers aware of incoming nasty weather. Others have taken more technologically advanced approaches, including portable systems that measure static electricity buildup over more than a dozen miles. Some golf courses have their own electrical storm identification systems, tracking lightning strikes within a 30-mile radius.

Other outdoor adventurers tend to receive more than their fair share of lightning strikes as well, including swimmers, campers, hikers, hunters and fishing enthusiasts.

Dodging the Deadly Bolts
How far are you from danger? The tried-and-true “flash to bang” method is an invaluable rule of thumb. When you see the flash from a lightning bolt, count the number of seconds between the flash and the bang from the resulting thunder. Divide that number by five, and the result is the number of miles the lightning is away from you. Anytime the thunder follows the flash by 30 seconds or less (i.e., six miles away or less), head for cover.

Indoors or out, take the following tips to keep from becoming lightning’s next target:

- **Check the weather:** Like a sentry posted on eternal guard, the National Weather Service scans the skies in search of trouble. If the weather looks questionable, turn on the television or radio and listen for the NWS’ thunderstorm “watches” and “warnings.” A thunderstorm watch tells listeners that conditions are favorable for severe weather to spring up. A warning, however, means severe weather is already on the scene.

- **Pay attention to nature’s audio early warning system:** Lightning often strikes before rain ever makes an appearance. In fact, even a blue sky above is no guarantee of safety. Lightning can strike from as far away as 10 miles from a rain cloud. Thunder is a better warning indicator that trouble may be afoot. If you hear thunder, you’re close enough to the storm to be a prime target. Head for shelter immediately.

- **Keep an eye out for indoor shelter:** If trouble’s brewing above, be sure you
know where the nearest safe structure is, and how long it will take to make it there. A safe structure is any building with electrical wiring or plumbing that can electrically ground the structure. Those in search of shelter during sports will want to steer clear of shower facilities in their search for safety. In addition and never, never use plumbing facilities or showers when a thunderstorm is in full fury.

- **Avoid becoming an outdoor lightning rod:** If you’re stuck outdoors without a chance to seek shelter, stay far away from tall, isolated objects such as trees, light poles, fence posts or towers. Those trapped in wooded areas should find shelter under shorter trees. Remove hats and toss any metal objects away from your body, including everything from metal hair pins to metal screws in a pocket.

- **Have a golfing escape plan:** Golfers caught outdoors in a lightning storm should make their way back to the clubhouse, but be sure to keep at least 20 feet between golfing partners. That reduces the chance of a bolt’s electrical energy “splashing” out to nearby individuals. Stay far away from the seeming shelter of a golf cart. Ditching shoes with metal spikes is also a wise precautionary measure.

- **Cars can be safe harbors:** If you can’t make it to a safe building, retreating to a car is a good idea in a thunderstorm. Make sure the car is enclosed with all the windows rolled up, and be sure to avoid touching anything that’s metal. The safety secret of cars isn’t in their rubber tires. Instead, the hard metal roof of an automobile absorbs and dissipates a lightning strike around the car.

- **Know the warning signs of an impending strike:** When your hair stands on end or your skin starts tingling, a lightning bolt is likely ready to strike near you. Make yourself as small a target as possible by crouching low to the ground with your hands on your knees and your head tucked in. Lightning doesn’t always strike from above. Many victims are actually hit by lightning moving up from the ground they’re standing on. Rest on the balls of your feet to minimize contact with the ground. Don’t lie on the ground, you’ll only turn yourself into a larger target.

- **Be smart indoors:** Just because there’s a roof between you and a lightning bolt doesn’t mean you’re completely safe. Physical contact with anything that can conduct electricity from outdoors can be dangerous. The list of definite indoor no-no’s includes using corded telephones, touching running water, being in contact with electrical appliances and touching metal window frames and doors.

- **If the unthinkable happens, jump into action:** If lightning strikes a companion, call promptly for emergency services. Those hit by lightning don’t become “live wires” themselves, so it’s safe for rescuers to begin CPR and other emergency measures immediately.

- **Once lightning stops, take a time out before taking the field again:** Getting back into the game or outdoor activities shouldn’t be rushed. Sit tight for at least 30 minutes after the last lightning flash or thunder clap before picking up outside where you left off.

So, the next time the rolling sound of thunder hits your ears, remember: While the gods may have vanished into myth, their terrible weapon remains, as mysterious, powerful and destructive as ever.

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**Want more facts on the incredible power and peril of lightning? Get the straight story from these organizations:**


- **The Lightning Injury Research Program at the University of Illinois-Chicago** tracks the physical toll taken by lightning and outlines medical treatments. Check out [tigger.uic.edu/labs/lightninginjury](http://tigger.uic.edu/labs/lightninginjury).


For those interested in finding out where lightning strikes are an immediate danger, Intellicast offers a national map of lightning hits within the last 30 to 90 minutes. Check out the map at [www.intellicast.com/localweather/world/unitedstates/nationallightning](http://www.intellicast.com/localweather/world/unitedstates/nationallightning).

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New Vaccine Fights Staph Infections

Researchers at the National Institute of Child Health and Human Development, a part of the National Institutes of Health, say they have developed the first vaccine against “staphylococcus aureus,” a major cause of infection and death among hospital patients. Clinical trials conducted at the biologic firm Nabi showed the vaccine to reduce the occurrence of bacteremia, a blood infection caused by staph, by 57%.

Hospital-acquired staph infections cause illnesses ranging from minor skin infections to life-threatening diseases such as severe pneumonia, meningitis, bone and joint infections, and infections of the heart and bloodstream. Patients undergoing hemodialysis for end stage kidney disease are particularly susceptible to staph blood infection, with nearly 3% developing the infection each year.

The vaccine may be a route to overcome the increase in strains of staph that are becoming resistant to methicillin, the antibiotic used to treat it. The study appeared in the February 14 issue of the New England Journal of Medicine. For more, go to www.nih.gov.

Hospitalists’ Use Yields Benefits

The Journal of the American Medical Association (JAMA) reported that most studies of hospitalists—physicians who focus exclusively on hospitalized patients—show that the rapidly growing medical specialty is successful at reducing costs and average lengths of stay without any measurable decrease in quality of care.

In 15 of 19 studies reviewed for the JAMA article, hospital lengths of stay fell an average of 16.6%, leading to an associated drop of 13.4% in hospital costs. Data revealed no evidence the model led to diminished quality, according to researchers involved with the studies.

Robert Wachter, M.D., associate chair- man of the department of medicine at the University of California, San Francisco, who first coined the term “hospitalist” in 1996, co-authored the article. He said inpatient costs nationwide could be reduced by almost $2.4 billion per year if each of the estimated 5,000 hospitalists now practicing cared for 600 patients and generated a 10% savings on the average total inpatient bill of about $8,000.

Wachter estimates that hospitalists are practicing at approximately one-third of America’s hospitals. He believes the number of such in-hospital specialists will balloon to 19,000 or more by the end of the decade, enough to cover every hospital in the nation.

ER Training Videos Available

The Arizona Hospital and Healthcare Association (AzHHA) in Phoenix has produced two videos originally designed to help hospitals there deal with the record numbers of patients being seen in their emergency departments. The videos cover issues such as Emergency Medical Treatment and Active Labor Act (EMTALA) compliance and emergency department efficiency. AzHHA is now making those videos available to hospitals in other states interested in purchasing copies.

One video, “Learning to Live with EMTALA,” is a training video and resource manual that was developed in conjunction with AzHHA legal counsel and an emergency physician. It features actual scenarios that educate staff on the key requirements of EMTALA law. The price for this training tool is $199, which includes the 55-minute video and the comprehensive resource manual that provides guidance for in-house training as well as materials for easy reference and note taking.

“Improving Throughput in the Emergency Department” provides information on strategies for improving efficiencies in the emergency room; reducing patient waits; and increasing customer satisfaction. The price for this tool is $80, which includes a 45-minute video and presentation handouts.

Preview clips are available for both videos on AzHHA’s Web site at www.azhha.org (go to the Education section). Additional information and the ability to order online is also available on the website. For more information, contact Jan Lemon-Saquella at (602) 445-4300, ext. 4313 or jsaquella@azhha.org.

New Medicare Ambulance Fee Schedule

The Centers for Medicare & Medicaid Services February 22 announced a final regulation creating a new ambulance fee schedule. Under the rule, ambulance service providers will be paid a pre-established fee for each service provided similar to those paid to hospitals, nursing homes, home health agencies, and other providers.

The rule also requires ambulance service providers to accept the Medicare approved fee as their full pay-ment, meaning beneficiaries will not have to pay more than 20% of the approved amount after meeting their annual $100 Medicare Part B deductible.

The rule will be phased in over five years beginning April 1. The negoti-ating committee that developed the fee schedule did so with particular concern for beneficiary access in rural areas. For more information, go to www.hcfa.gov/regs/regsnotices.htm.
AHA Releases Patient Safety Standards

The American Hospital Association, the Federation of American Hospitals and the Healthcare Leadership Council recently unveiled a new report and criteria to evaluate proposed patient safety and quality standards.

The report, *The Challenge of Assessing Patient Safety in America’s Hospitals*, is meant to function as a framework for measuring the relevance, appropriateness, quality, and implementation feasibility of patient safety standards released by various groups.

Formulated by Protocare Sciences, the report says there are many good practices with evidence to support their use, but there are also practices that lack enough flexibility to be used by all hospitals. For the report, click on www.aha.org/PatientSafety/whatsnew.asp.

Speakers Predict 2002 Hospital Issues

Based on comments made before a recent meeting of the American Health Lawyers Association, the most important issues that hospitals and health systems will be confronted with in 2002 are: (1) privacy of health information, (2) emergency treatment, (3) physician self-referral, (4) physician recruitment and other relationships with hospitals, (5) billing fraud and abuse, and (6) regulation of hospitals.

Speakers addressing the conference also identified their expectations for top enforcement areas to be (1) cost report investigations, such as bad debt reporting, (2) billing by physicians at teaching hospitals (PATH audits), (3) application of Emergency Medical Treatment and Active Labor Act (EMTALA) rules, (4) long-term care, (5) cost outlier payments, (6) and hospital inpatient diagnosis-related group (DRG) coding.

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Hospitals are at the one-year delay, which is available to delay compliance with the Transactions and Code Sets rule by one full year—until October 16, 2003. However, in order to qualify for the deadline extension, entities must submit a compliance plan to the Secretary of the Department of Health and Human Services (HHS) by October 16, 2002.

That plan must include a budget, schedule, work plan, and implementation strategy for achieving compliance. HHS has been instructed to develop and issue by March 31, 2002 a model form that may be used in developing the plan. The American Hospital Association has provided guidance on the one-year delay, which is available at www.aha.org/hipaa/resources/extension.asp. Hospitals are advised that this delay in no way affects the privacy regulation compliance deadline of April 14, 2003.

Arkansas Credentialing Service Operational

The Arkansas State Medical Board’s Centralized Credentials Verification Service (CCVS), the nation’s first medical board-based Credentialing Verification Organization (CVO) established under Arkansas Act 1410 of 1999, became operational in January.

Under the act, all Arkansas hospitals, HMOs and other organizations that credential physicians (MDs and DOs) will be required to utilize the CCVS for obtaining their credentialing information. Use of the system is required by Act 1410 of 1999.

Questions about the CCVS program and how it works, should be directed to Toni Moring, CCVS Program Manager, at 501-296-1952 or ccvs@armedicalboard.org.

New CDC Bioterrorism Web Resources

The Centers for Disease Control and Prevention (CDC) has launched a redesigned Web site offering new and updated bioterrorism resources for health professionals and the public.

The Web site, www.bt.cdc.gov, focuses on public health preparedness and emergency response. It is the official federal Web site for medical, laboratory, and public health professionals to reference for obtaining information on updates and protocols related to health threats such as anthrax. It offers user-friendly categories requested by target audiences such as clinicians.

The site was redesigned in response to overwhelming public demand in the wake of the recent anthrax crisis in several eastern U.S. cities. In October, CDC had the most-visited federal Web site, registering more than 9.1 million unique visits.

Arkansas Hospitals Challenge UPL Rule

The Arkansas Hospital Association (AHA), Ashley County Medical Center in Crossett, and Delta Memorial Hospital in Dumas were among the plaintiffs filing a lawsuit in federal court March 7 to block the federal Department of Health and Human Services from implementing its new Medicaid upper payment limit (UPL) rule. That rule, if implemented, will cut Medicaid’s upper payment limit program by $27 billion over 10 years. The suit was filed in U. S. District Court in Little Rock.

Other plaintiffs seeking to stop implementation of the rule include the American Hospital Association, the National Association of Public Hospitals, the National Association of Children’s Hospitals, the Association of American Medical Colleges, and state hospital associations in California, Florida, Georgia, and New York. Individual hospitals in those states and Minnesota are participating in the lawsuit as well.

Late in 2001, Congress specifically requested that the Bush Administration carefully consider the impact of any change in the rule that would affect special public hospital payments, and not act precipitously to eliminate them. Despite this congressional directive, the Administration moved ahead with these regulations.

Arkansas’ 41 non-state public hospitals would lose approximately $20 million a year if the rule took effect March 19 as scheduled. The AHA’s "declaration" notes that the UPL reduction would undermine those 41 public hospitals, 29 of which are the sole hospitals in the mostly small rural counties where they are located.

The declaration further states that 46% of these hospitals face a very real threat of closing or imposing deep service cuts due to reduced revenues in a state where 400,000 people have no health insurance, the median family income is 26% below the national average, and the age-adjusted death rate is 20% higher than the U.S. rate.

The lawsuit argues that HHS violated the Administrative Procedures Act in promulgating the final UPL rules, making an arbitrary and capricious decision that will cause irreparable harm to the nation’s public hospitals and the patients they serve, including those who are poor, uninsured, and disabled.
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Creating Consistent Health Care Across the Community

By Richard Pope, MD, Senior Medical Scientist, Medical Information Technology, Inc., Westwood, Massachusetts

Health care in the 21st century is being defined by an increasing number of decisions and choices facing both patients and care providers. Gone are the days when a community consisted of a single hospital or clinic and patients dealt with one doctor for an extended period of time. Today's health landscape includes primary care physicians that frequently change, and a growing list of medical specialists and therapists. Myriad care settings across the community include hospitals, clinics, private physician practices, rehabilitation centers, and long-term-care facilities.

Increasing along with the types of providers and settings is the prevalence of chronic diseases. Industry analysis finds that approximately half of all adult Americans and one-third of all children in this country suffer from some sort of chronic disease, with a large portion of Americans over the age of 65 coping with two or more chronic ailments. For care providers, managing the wide range of issues created by this new health landscape, while at the same time delivering the highest quality of care are the paramount challenges within the industry today.

In the last three years, the Institute of Medicine (IOM) has distributed a pair of highly publicized reports identifying health care's most urgent problems and offering potential solutions. The 1999 IOM report, “To Err is Human,” focused on the high number of patient errors occurring in care facilities and highlighted the need for automated systems that help decrease common mistakes. In 2001, the IOM issued its “Crossing the Quality Chasm” report, which declared, “The American health care system is in need of fundamental change.” Because patient requirements have changed in recent years, a brand new approach to care delivery is required to provide the highest level of quality. One step in the right direction is adopting new technologies that assist in increasing efficiency, streamlining processes, and establishing an environment that encourages information sharing. In addition, the growing influence of the Internet needs to be taken into account, as both patients and care providers are increasingly using this tool as an essential information resource.

Creating a health community that can meet today’s new challenges won’t happen over night, but the good news is that proven technological solutions have emerged in the industry. And these tools aren’t just available to the biggest care systems with gargantuan budgets. Small facilities and care settings in rural areas are taking advantage of advanced systems as well—a key development that facilitates information sharing.

One approach that has demonstrated successful results is the incorporation of an integrated Health Care Information System connecting all care settings—the emergency room, the inpatient clinical setting, the physician’s office, the rehabilitation clinic, and anywhere else care is provided. An automated enterprise information system facilitates effective care delivery anywhere, anytime. Information is presented in a logically organized fashion, and security features enable multi-
ple users to access patient records. An enterprise information system also utilizes a common database of patient data that adheres to specific industry standards and allows users to customize the system’s functionality. The system provides necessary decision support capabilities and enables a higher standard of care.

By establishing an enterprise information system, the patient becomes the center of a physician-driven model of care delivery. From a variety of locations across the community, physicians can review all the data collected on a specific patient and make decisions based on that collective knowledge. Armed with this information, the physician can create a patient work list detailing specific tasks and perform such functions as entering orders into the system. From a desktop computer, the physician is now monitoring a full roster of patients through manageable, organized processes.

Patient information is cataloged into a permanent electronic record that can be accessed across the health enterprise. This saves time and increases efficiency when the patient is being treated by someone other than his primary care provider. If a patient is rushed to the emergency room with chest pains, for instance, a nurse or attending ER physician can quickly pull up that individual’s electronic record and check his medical history, identify current health issues and management needs, see if he has allergies to particular medications, or if he requires any sort of specialized treatment. When time is of the essence, the ability to find vital information as soon as possible can be the difference between life and death.

Beyond the walls of clinical facilities, new tools for home health care are now reaching the market that allow patients to have more autonomy over their treatment. This is especially important with respect to the large number of individuals dealing with chronic diseases. A physician can provide a patient suffering from diabetes with a handheld device programmed to sound an alert when it’s time to take insulin. The device can also display helpful information and provide phone numbers or e-mail addresses when it is appropriate to contact clinicians for further assistance. In addition, the device allows caregivers to remotely monitor their patients’ health progress.

The use of handheld devices is also increasing within traditional care settings as clinicians utilize tools that enable them to collect patient data and enter it into the enterprise system directly from the point of care. This can be done to manage workflow and capture charges in the clinical setting, to gather data that will be sent to ancillary services, or to keep real-time track of equipment and resources dedicated to the patient. Manually collected information can be downloaded into the central system through a PC, and information gathered from bar-code scanners can be downloaded into the system as well.

By linking all the various aspects of the care continuum to a common technology platform, the entire organization reaches out to the community and creates a healthier environment. The enterprise information system provides the foundation for this cooperative approach to quality care involving both patients and care providers.

Dr. Pope has been with Medical Information Technology, Inc. (MEDITECH) for more than 15 years helping to develop industry-leading Health Care Information Systems.
At its recent annual surveyor conference, Joint Commission on Accreditation of Healthcare Organization (JCAHO) staff emphasized the need for surveyors to focus on an organization’s emergency management preparations. In particular, it was stressed that surveyors carefully evaluate:

a. Hazard Vulnerability Assessments (HVA’s) that identify all potential hazards to the organization and how those hazards can directly and indirectly affect the organization;

b. Engagement with the community in emergency planning and practice drills;

c. Communication and planning in cooperation with other area health care organizations; and

d. The organization’s scalable command structure, or its ability to flex to the magnitude of a particular disaster.

In addition, surveyors will also focus on the revised intent statement to standard EC.1.4 that now includes sharing information about:

• Essential elements of command structures and control centers for emergency response.
• Names, roles and telephone numbers of individuals in command structures.
• Resources and assets that could potentially be shared or pooled in an emergency response.
• Names of patients and deceased individuals brought to their organizations to facilitate identification and location of victims of the emergency.

Another area of focus will be the new staffing effectiveness standards, which go into effect for hospitals in July 2002.

Beware of Phony HIPAA Auditors

Individuals posing as HIPAA compliance auditors approached a medical group and tried to gain access to the provider’s computers and database, according to a fraud alert from Louisiana Medicare Services. When they refused to produce identification or documentation confirming their identity, the billing manager denied access to the records.

Medicare contractors and government officials are not presently conducting on-site HIPAA audits. “Unless identification is provided, never allow anyone access to your computers, medical records, billing information, etc.,” reads the alert.

To read the complete alert, go to www.lamedicare.com/provider/CRS/fraud.htm.

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Joint Commission Resources Collects “Good Practices”

In January, the Joint Commission Resources (a subsidiary of the JCAHO) issued a call to encourage accredited hospitals to submit good practice examples related to patient safety, sentinel events, staffing, care of patients, and performance improvement.

Each example that is submitted must include information on:
- Staff involvement
- Tools and resources utilized
- How the example was implemented
- How the success of the good practice was measured
- Lessons learned or recommendations from the organization.

Examples that are accepted will also include advice, comments, and additional information resources from JCAHO experts for each of the five implementation steps. A $500 fee will be paid to hospitals submitting examples that are accepted for use by the JCAHO. All examples must be fully developed by the organization and must represent intellectually independent work. Examples referring to the use of any for-sale products or equipment will not be accepted.

Accepted examples will then be used to establish a good practices subscription database, which is scheduled to debut online later this year. The database will initially be limited to hospitals with expectations that it will be expanded to include accredited ambulatory care, long term and home care organizations in 2003.

Future topics for the good practice database will include environment of care, pain management, HIPAA, medical staff, assessment of patients, and human resources.

For information about submitting good practice examples or for additional information regarding the database, go to JCR’s website at www.jcrinc.com.

New Compliance Issues on the Horizon

Ready for new compliance problems? Speakers at the 5th National Congress on Health Care Compliance held recently in Washington, D.C. alerted participants to physician identity theft, fraud in office-based clinical trials, and a whole new area for health—cybercrimes.

James Sheehan, assistant U.S. Attorney and chief of the civil division, Eastern District of Pennsylvania, cautioned physicians and those working in practitioner offices to be alert for people “who have access to your system” that enables them to “steal your name and your physician identity number.” Conducting clinical trials in physician offices also is becoming a cause for concern and will lead to investigations, he said.

“Physicians need to explain to patients [that sign up for clinical trials] that the physician is receiving money to recruit patients,” Sheehan said. Physicians clearly need to tell patients that they may not be getting the drugs they are signing up for.

Cybercrime is a new area of federal health investigation, said Timothy Delaney of the FBI’s Health Care Fraud Unit. This newly created cybercrime unit will be looking into electronic billing. Unlike other units, it will be able to monitor phone lines. And, although he didn’t say so specifically, according to St. Anthony Publishing’s Part B Insider, the unit probably will get busier with the requirement for electronic billing of Medicare claims under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA also authorized an additional $111 million to investigate healthcare fraud and abuse.

Tom Scully, administrator of the Centers for Medicare and Medicaid Services, also at the conference, said, “Every dollar spent on a good compliance program is money the government doesn’t have to spend enforcing the law.”

AMA’s Free Bioterrorism Web-Based Training

The American Medical Association (AMA) has recently launched a series of web-based training programs (and free Continuing Medical Education) to help deal with the crisis of bioterrorism. The series features a number of the nation’s leading experts on the clinical, psychosocial, and disaster preparedness issues.

Because of the special nature of this crisis, the AMA is allowing this medical education to be accessed free of charge by all physicians. The complete series of presentations is available online and can be viewed anytime and anywhere, enhanced by the features of a media player. Any or all of the segments may be accessed and viewed. Go to www.ama-assn.org/go/interim2001CME.
Answers Regarding Transactions and Code Sets

Yes, providers can continue to use Healthcare Common Procedure Coding System (HCPCS) codes to bill for drugs on Health Insurance Portability and Accountability Act (HIPAA) test inpatient claims. In a recent memorandum, the Centers for Medicare and Medicaid Services (CMS) attempted to answer this question and many others that have confused providers since CMS eliminated some HCPCS codes and modifiers to comply with HIPAA’s transaction and code sets rule.

The memorandum also answered the following questions:
• How should the standard system maintainers process HIPAA production claims containing a non-numeric revenue code?
• How should HIPAA test claims that require subscriber demographic information be processed since Medicare has never required this information?

Go to http://www.hcfa.gov/pubforms/transmit/A02014.pdf to read program memorandum A-02-014.

Advisory On New OSHA Rule

As of January 1, hospitals and other employers must use new Occupational Safety and Health Administration (OSHA) forms for reporting on-the-job injuries and illnesses, and may use equivalent forms and computers to maintain those records, if those alternatives adhere to the rule published October 21, 2001.

The American Hospital Association (AHA) issued an advisory to all its member hospitals December 26 suggesting they review the new rule and its requirements, assign a point person to be in charge of record keeping, and talk to state enforcement agencies in those states with OSHA-approved state plans to ensure compliance.

The advisory noted that the agency also has issued new definitions regarding work-relationship, restricted work, and first-aid. But, the rule postpones for a year the record-keeping requirements issued last January 19 for ergonomic injuries while OSHA works to develop a more specific definition for ergonomic injuries and new methods for preventing them. The advisory is available in the members-only section of AHA’s Web site at www.aha.org.

OIG Questions ASC Quality

A new report from the Department of Health and Human Services, Office of Inspector General (OIG) points to possible quality oversight problems in the nation’s freestanding ambulatory surgery centers (ASC). The report says that quality in the ambulatory surgery centers is “lacking,” with nearly one-third of 3,000 surgery centers not being certified by state agencies in five or more years. Some facilities had not been inspected in nearly 10 years.

The OIG notes that federal standards for surgery centers haven’t been revised in two decades, despite a 740% growth rate in the number of surgical procedures performed on Medicare patients in the ASCs between 1990 and 2000. The Federated Ambulatory Surgery Association said the inspector general’s office also should have looked at quality oversight of hospital outpatient departments and physician offices.

For the complete report, go to www.oig.hhs.gov/oei/oei.html.
OSHA Inspecting Arkansas Hospitals

Arkansas hospitals that are not city- or county-operated can look forward to an unannounced visit by inspectors from the federal Occupational Safety and Health Administration (OSHA) in the coming weeks. OSHA inspectors have already appeared at six of the facilities with a stated purpose of looking for possible safety violations related to blood-borne pathogens.

Word from at least one of the hospitals is that the subsequent inspection was very meticulous, thorough, and detailed, included interviews with about 25 individual employees and took around two days to complete.

Items cited as violations included a stairway handrail (off-site of the hospital’s main building) that was too low and missing a mid-rail, the lack of an “immediate-access” eyewash in certain areas of the facility and several “hazardous communications” faults related to labeling issues. Hospitals that are operated by a city or a county are excluded from the inspections.

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