Suspicious Activity at Hospital Radiology Department

The Arkansas Department of Emergency Management reports that in mid-March two men with olive skin, speaking a foreign language to each other, removed material from a hospital in Pauls Valley, Oklahoma. A social engineering technique was used in which a person called the hospital in advance and asked for the Radiology Department. When the hospital employee answered the call, the originator of the call obtained the employee’s name. The caller used a ruse of “checking on the material levels in their processing tank” and then told the employee they were on the way to clean and remove materials. Upon arrival at the hospital the males asked for the radiology employee by name.

The “persons of interest” were described as (1) approximately 5’10”, wearing white cargo pants and T-shirt using the name “Austin” and (2) approximately 6’1”, wearing jeans and long sleeve shirt with black and white stripes on the arm. The two suspects left the hospital in a gray Toyota truck, after collecting what is thought to be x-ray silver reclaiming cartridges and exposed x-ray film. The hospital reported the theft to the police department.

This information is being provided for situational awareness. The suspects have reportedly been in contact with other Oklahoma hospitals in Sulphur, Ada, Lindsey and Oklahoma City. While the Oklahoma Department of Environmental Quality indicates no radioactive material was obtained, hospitals are encouraged to be vigilant and report any suspicious activity to the Arkansas State Fusion Center at (866) 787-2332 or arfusioncenter@asp.arkansas.gov. Should such activities appear to present an imminent threat, local law enforcement should be notified.

2011 Mid-Management Workshops Begin April 5

The Arkansas Hospital Association (AHA) will offer the first two courses (a live workshop and a Webinar) in the 2011 Mid-Management Healthcare Leadership Series next month. The workshop series is designed to help both new and veteran management level employees to learn, or review, realistic and workable techniques for managing and leading people in their hospitals, and to assist member hospitals in developing leadership skills and competencies among their current employees.

“Great Leaders Help Others Act on Their Best Intentions: Effective Leadership in a Healthcare Organization” will be held April 5 in the AHA classroom. Leadership consultant Susan Keane Baker will facilitate, just as she did at last year’s AHA Annual Meeting to a very satisfied crowd. Susan will discuss four areas of leadership in the five-hour workshop. They are:

- How to influence exceptional effort
- How to be the leader everyone wants to work for
- Poor performers: love them or leave them
- 50 ways to enhance colleague-to-colleague relationships
“Legal Issues for Healthcare Leaders,” a Webinar by Little Rock attorney and frequent AHA contributor Lynda Johnson, will be offered April 21. This Webinar will examine legal issues such as HIPAA regulations and patient rights, labor relations and employment laws, and compliance statutes and regulations.

The Mid-Management Healthcare Leadership Series consists of six live programs and three Webinars that build on the premise that managers represent the hospital and are the primary factor for determining an employee’s desire to work for that hospital. While the workshops and Webinars are marketed as a series, participants may choose to attend them individually, as well. Individuals seeking an AHA Mid-Management Certificate must attend and complete at least five of the live programs and one Webinar. The registration fee for each program (except for the October 5 workshop) is $145 and each Webinar is $180. A copy of the brochure is available at http://www.arkhospitals.org/events/mid-management-healthcare-leadership-series.

New EPA Rule Covers Hospital Boilers

In response to federal court orders requiring the issuance of final standards, the U.S. Environmental Protection Agency (EPA) on February 23, 2011, issued final Clean Air Act standards for boilers and certain incinerators. The standards are meant to achieve significant public health protections through reductions in toxic air emissions, including mercury and soot. The EPA says that they will cut the cost of implementation by about 50% from an earlier proposal issued last year. Among other types of facilities, these rules will impact existing boilers at hospitals and other facilities throughout Arkansas.

While the primary targets of the new rule are boilers located at large sources of air toxics emissions, such as refineries, chemical plants and other industrial facilities, it also affects boilers located at small sources of air toxics emissions. These small sources of air pollutants typically are found at universities, hospitals, hotels and commercial buildings. Due to the small amount of emissions these sources are responsible for, EPA has limited the impact of the final rule making on small entities. The original standards for these have been dramatically refined and updated to ensure maximum flexibility for these sources, including for some sources, revising the requirement from maximum achievable control technology to generally available control technology.

Find more information on the new rule posted under the “Hot Topics” section of the Arkansas Hospital Association Web site, www.arkhospitals.org. Other information is available at http://www.epa.gov/airquality/combustion. Because of the rush court ordered schedule for these final rules, and the fact that the federal standards differ significantly from the original proposal, EPA will accept comments for 60 days under a reconsideration process.

Registration for the EHR Incentive Programs

CMS is planning two upcoming National Education Calls on Registration for the EHR Incentive Programs. The first call is targeted at eligible professionals who are interested in the Medicare Incentive Program. It will be held on Friday, April 1 (12:30-2:00 p.m. CST). Then, on Wednesday, April 6 (12:30-2:00 p.m. CST) the call will be tailored for eligible hospitals hoping to register for the Medicare and Medicaid Incentive Programs. Both calls will cover eligibility for incentives, switching between the Medicare and Medicaid Incentive Programs, reassigning payments, pre-registration, registration and helpful resources. In order to receive the call-in
information for either of these calls, participants must register. (Note that if you are planning to sit in with a group, only one person needs to register to receive the call-in information.) Registration will close at 12:30 p.m. CST on the day before each of the calls or when available space has been filled; no exceptions will be made, so please register early. To register, visit http://www.eventsvc.com/palmettogba/040111 for the April 1 call or http://www.eventsvc.com/palmettogba/040611 for the April 6 call.

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**Error Affects processing Some Hospice Claims**

CMS recently discovered an error affecting some hospice claims editing inappropriately on the covered units. In some cases, hospice claims were being returned to providers (RTP’d) in error with reason code 31503. CMS now has instructed Medicare contractors to hold hospice claims editing with reason code 31503 until a correction is installed on Monday, April 4. Hospice providers may resubmit claims that have been RTP’d in error for reason code 31503 for reprocessing after verifying that the units reported on the claim are correct. All claims being held with this edit will be released immediately upon installation of the correction to the system.

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**Breast Cancer Research Oversight Committee**

The Arkansas Hospital Association (AHA) has been asked to submit to the Governor’s office nominations of hospital representatives who might serve on the state’s Oversight Committee on Breast Cancer Research. The committee advises UAMS on cancer research issues. It meets one time per year and the term covers four-years. Interested individuals should contact AHA president, Bo Ryall at boryall@arkhospitals.org.

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**The AHA Calendar**

March 2011
24 Keeping Updated on Infection Prevention: A Patient Safety and Payment Imperative – Webinar T2655
28 Orlikoff Reinertsen Boardworks TM Presents Health Care is Still Unsafe: What Boards Need to Do About Patient Safety – Webinar
29 Infection Control Standards Update, Crowne Plaza, Little Rock
29 Using Data Transformation to Improve the Environment of Care – Webinar T2656
29 New Provider Payment Models: PROMETHEUS and More and Why – Webinar T2657
31 Arkansas Society for Directors of Volunteer Services (ASDVS) Spring Meeting, AHA Classroom, Little Rock
31 CMS Equal Visitation Rights: Ensuring Compliance – Webinar T2658

Information on all AHA educational programs and activities is available at www.arkhospitals.org/events.

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Final Thoughts by Paul Cunningham

Come gather 'round people wherever you roam, And admit that the waters around you have grown
And accept it that soon you’ll be drenched to the bone. If your time to you is worth savin’
Then you better start swimmin’ or you’ll sink like a stone. For the times they are a-changin’.

Bob Dylan

The plan unveiled two weeks ago to revamp the way Arkansas Medicaid pays for services has generated quite a stir, and little of it could be described as supportive. For proof, look no further than the two multi-column articles that have appeared in the Arkansas Democrat-Gazette over the past few days. On the other hand, the outcry should have come as no surprise. After all, the plan that’s being touted represents less of a change in the program than a metamorphosis. It takes a payment structure everyone knows, one which has been in place for 40-plus years, and not only gives it a complete makeover to where it is barely recognizable, but also expresses the intent to do it in less than 18 months. No wonder nerves are frayed.

It’s not as if doctors, hospitals, home health agencies, therapists, dentists, mental health professionals and a host of others don’t agree that some kind of change is needed. They see the same numbers and can do the math. They understand that there isn’t enough state general revenue to keep the Medicaid boat afloat after fiscal year 2013 unless spending can be reeled-in, and that the agreement on six tax cut bills in the Legislature last week could mean even less. They care for growing numbers of needy children and adult Medicaid recipients every day and grasp the harsh reality that more — many more — are on the way in a few years.

They realize that change is inevitable and that, yes, it could involve episodic care and bundled payments. What they do not understand is why nobody bothered to bring them into the conversation before springing such a major proposal with no advance warning, much less an invitation to sit down to develop the concept jointly from the outset. Getting folks who are supposed to be a part of a plan clued-in on the front end is always the better option.

Department of Human Services and Medicaid officials say their plan is not feasible without the providers’ buy-in, and now are urging providers to get on board. The train’s already coming down the tracks. Medicaid’s provider community prefers that it stop at the station, allowing them step on, rather than trying to snatch them aboard like bags of mail while passing at top speed. There are assurances that future discussions centered on the real details of the proposal to address concerns will be conducted in concert with them in a very open public fashion. The hope is that’s exactly what will happen, because there are significant concerns to address.

For Arkansas’ hospitals, one of the chief concerns about the plan is the stated purpose to design and implement a statewide payment initiative “in conjunction with Medicare, Arkansas Blue Cross and Blue Shield and other third party payers.” It goes on to indicate that, if implemented, Medicare and private insurers would align their pricing policies with Medicaid.

True or not, that sort of language raises a red flag that Medicaid is taking deliberate steps toward a single payer system based on Medicaid rates! If more state dollars down the line are unlikely, then you have to assume that Medicaid won’t be able to increase its rates appreciably. So, the idea of having other payers align their rates with Medicaid, which covers a dwindling percentage of hospitals’ operating costs every year, clearly does have folks on edge.

There’s more, too. The lack of detail leaves us to fill in the blanks, but it seems that the aggressive time frame makes key elements of the plan impractical. An infrastructure to process claims for the bundled payments and statewide health information exchange capabilities to track and reduce duplicative services must be in place and operationally effective by July 1, 2012; and actuarially sound payment rates for an array of episodic care centered on literally hundreds of CPT and ICD-10 codes would need to be ready within a year. Both sound highly unlikely.

Medicaid director Gene Gessow knows that his vision of change won’t be easy. But, he notes that just because change is difficult doesn’t necessarily make it impossible. That may be true. As long as one is willing to accept the corollary truth that sometimes it is.