On December 1, 1995, CBO completed a cost estimate for H.R. 2402, the Snowbasin Land Exchange Act of 1995, as ordered reported by the House Committee on Resources on November 16, 1995. H.R. 2402 contains provisions that are very similar to those of Title I of H.R. 3907, and the estimated costs for those provisions in the two bills are identical.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Deborah Reis and Victoria V. Heid (for federal costs), who can be reached at 226–2860, and Marjorie Miller (for the state and local impact), who can be reached at 225–3220.

Sincerely,

JUNE E. O'NEILL,
Director.

TRIBUTE TO EVESHAM TOWNSHIP POLICE CHIEF NICHOLAS L. MATTEO

HON. JIM SAXTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 31, 1996

Mr. SAXTON. Mr. Speaker, I rise to take this opportunity to congratulate and recognize the distinguished career of Chief Nicholas L. Matteo, chief of police for Evesham Township in Burlington County, NJ. Chief Matteo is preparing to retire on January 1, 1997 upon completion of more than 30 years of faithful service to the Evesham Township Police Department.

A native of Medford, NJ, Chief Matteo began his career with the Evesham Township Police Department responding to calls as a patrolman in 1966. As a cop on the beat, Chief Matteo served his community during time of need and emergency situations.

Mr. Matteo then ascended to the rank of detective first class where he was responsible for interviewing victims, perpetrators, and the follow-up of criminal investigations.

Patrol sergeant, the next title held by Mr. Matteo, entailed the overseeing of the operations of an entire patrol shift as well as direct supervision of critical incidents.

Chief of police is the rank that he has held honorably since 1990. He has been responsible for the operation of a large, widely respected law enforcement agency. While serving as chief of police, Mr. Matteo has earned the respect of the men and women of the Evesham Township Police Department, as well as residents of Burlington County, by participating on the Burlington County Chiefs Association Executive Board.

In 1996, the Delaware Valley Chiefs Association named him to their executive board. This is a most prestigious honor. This appointment highlights Chief Matteo's genuine concern for protecting the safety of the residents of his own community as well as those surrounding it.

Chief Matteo's dedication to his community is not limited to his duties and responsibilities as a police officer. He is also keenly aware of the need for racial harmony and tolerance throughout our country. He promotes this ideal through the Coalition of Multi-Culture Understanding of Burlington and Camden counties, of which he is president.

Be it a patrolman, an administrator, or a supervisor, Chief Nicholas L. Matteo has been an excellent role model for other uniformed officers and citizens of the United States. Mr. Speaker, I am honored to submit these commemorative remarks in order to share the many accomplishments of a great man with my colleagues.

A man of Nicholas Matteo's stature and vision is rare indeed. While his distinguished service will be genuinely missed, it gives me great pleasure to recognize him, and to wish him good luck as he brings to a close a long and dignified career with the Evesham Township Police Department.

WILLIAM H. MORTON ENGINE CO. NO. 1 CELEBRATES 125TH ANNIVERSARY

HON. GERALD B.H. SOLOMON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 31, 1996

Mr. SOLOMON. Mr. Speaker, anyone who visits my office can't help but notice the display of fire helmets that dominate my reception area. They're there for two reasons. First, I had the privilege of being a volunteer fireman in my hometown of Queensbury for more than 20 years, which helps explain the second reason, the tremendous respect that experience gave me for those who provide fire protection in our rural areas.

Mr. Speaker, in a rural area like the 22d District of New York, fire protection is often solely in the hands of these volunteer companies. In New York State alone they save countless lives and billions of dollars worth of property. That is why the efforts of people like those firefighters in Athens, NY, is so critical.

And that's why, Mr. Speaker, back in 1870 the residents of the growing village of Athens demanded more fire protection and the William H. Morton Engine Co. was born in 1871. It was founded based on this need to serve one another.

On that note, Mr. Speaker, those are the traits that make me most fond of such communities, the undeniable camaraderie which exists among neighbors. Looking out for one another and the good of the whole is what makes places like Athens a great place to live and raise a family. And this concept of community service couldn't be better exemplified than by the devoted service of the fine men and women who have comprised the William H. Morton Engine Co. No. 1 over its 125-year history. That's right, for well over a century, this organization has provided critical services for the citizens of Athens on a volunteer basis. As a former volunteer fireman myself, I understand, and appreciate, the commitment required to perform such vital public duties.

Mr. Speaker, it has become all too seldom that you see fellow citizens put themselves in harms way for the sake of another. While almost all things have changed over the years, thankfully for the residents of Athens, the members of their fire department have selflessly performed their duty, without remiss, since back in 1871.

You know, I have always said there is nothing more all-American than volunteering to help one's community. By that measure, Mr. Speaker, the members of the William H. Morton Engine Co. No. 1, past and present, are truly great Americans. In that regard, I ask that you, Mr. Speaker, and all Members of the House, join me now in paying tribute to these dedicated men and women.

FUNDING FOR THE FEDERAL MARITIME ACADEMIES

HON. JACK FIELDS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 31, 1996

Mr. FIELDS of Texas. Mr. Speaker, I am deeply concerned about the viability and sustainability of our 6 State maritime academies given this bill's funding level for the Maritime Administration's operation and training account. This portion of the Commerce, Justice, State appropriations bill does not specifically provide funding for the 6 schools and actually cuts $4.3 million from the operation and training account that was to have funded the schools.

The State maritime academies represent a model of State and Federal cost sharing in meeting the Nation's need for officers for the American flag merchant fleet and other elements of the maritime industry. The students and State governments underwrite most of the schools' costs. The Federal Government historically has assisted the academies by loaning them training ships used to meet the Federal mandate for the sea time required to fulfill the Coast Guard licensing requirements. The schools maintain these ships at approximately one-third the cost of maintaining Ready Reserve Fleet ships.

The mission of the State maritime academies is to provide, in partnership with the Federal Government, licensed American merchant marine officers by the most cost-effective means. The 6 schools, located in Maine, Massachusetts, New York, Texas, California, and Michigan provide 75 percent of the Nation's licensed mariners.

These State maritime academies represent a high return on a modest Federal investment. For only $9.3 million, which represents level funding over the past 7 years, they train and graduate 75 percent of the Nation's licensed merchant marine offices; maintain a Ready Reserve Fleet ships at one-third the Government costs; commission an additional 100 Navy and Coast Guard Reserve officers each year; and enjoy a 100 percent job placement rate for graduates.

I, along with many others on both sides of the aisle, hope the Senate will fully fund these much-needed State maritime academies. I also urge House appropriations conferees to work with the Senate to restore this funding.

A TRIBUTE TO WOODS MEMORIAL HOSPITAL

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 31, 1996

Mr. DUNCAN. Mr. Speaker, I want to congratulate Woods Memorial Hospital in Etowah, TN, for being nationally recognized for its success in advanced technology as well as its overall business success.

In addition to its national recognition, the hospital was honored with the Tennessee

Quality Commitment Award and received accreditation with commendation from the Joint Commission on Accreditation of Health Care Organizations earlier this year. These are fine honors which the hospital should be very proud to receive.

Despite the growing shortage of quality medical care in our rural communities, Woods Memorial Hospital remains dedicated to providing its patients with the best technology and high quality care from its professional staff. I am proud to have Woods Memorial Hospital in the 2d district of Tennessee.

I request that a copy of the article ''Critical Care'' which appeared in Inc. Technology be placed in the RECORD at this point. I would like to call it to the attention of my colleagues and other readers of the RECORD.

CRITICAL CARE—CASE STUDY

(By Joshua Macht)

The gurney crashes through the emergency room doors. On it lies a woman, lips pale, fading in and out of consciousness. In the glare of harsh lights, a quickly gathering knot of doctors and nurses steps into crisis mode. Needles, probes, and paddles move in and out of hands; a blood-sample is raced to the hospital laboratory. Moments later the lab sends the test results electronically to the emergency room: the woman's blood pressure is low; she must be losing blood. Images from a pelvic ultrasound are quickly delivered to a radiologist.

Around the corner, in the operating room, the surgeon prepares for the unscheduled morning performance. Before he scrubs, he dials a voice-mail box and retrieves a radiologist's interpretation of the ultrasound. The diagnosis: a ruptured fallopian tube and massive internal bleeding. The doctors suspect an ectopic pregnancy (an inseminated egg attaches to the wall of a fallopian tube instead of the uterus); the embryo has to be removed. Barely an hour and a half after the woman is rushed to the hospital, she's on the operating table; soon she's recovering in her hospital bed.

A routine crisis for one of the nation's big-city, high-tech hospitals. Except for one thing. This scene is taking place in tiny Woods Memorial Hospital, a 72-bed non profit hospital in Etowah, Tenn., a rural community halfway between Chattanooga and Knoxville.

Big changes are going on in health care, leaving hospitals across the country reeling from skyrocketing costs, a glut of beds, and all-out efforts by the government and the insurance industry to reduce treatment and reimbursement. Large urban hospitals, though they've felt the squeeze, are often able to weather the crisis because they've invested in sophisticated medical technologies that attract patients and in high-powered information systems that improve efficiency and manage costs.

But smaller hospitals typically don't have the money or the expertise to practice high-tech medicine or to buy computers. Those are some of the reasons small hospitals are collapsing or being swallowed up by larger competitors at an unprecedented rate. The crisis is all the greater for small hospitals like Woods that are located in rural areas, away from large pools of potential patients and technological know-how.

Woods, however, is thriving. Outpatient care is at its highest level ever, while patient revenues swelled from $16 million in 1991 to $28 million last year. Net income, even allowing for money that will never be recovered from federal, state, and private health-care subsidies, rose to $1.6 million in 1995 from $953,327 in 1991.

What makes Woods different? Three and a half years ago, the hospital began to transform itself. The focus: cost containment. The method: automation. Led by an administrator who has applied a near-military zeal to the task of automating every aspect of the institution's operations. Woods has proved that even organizations caught in the vortex of an industry's downward spiral can buck the trend.

Etowah is a sleepy town of 4,500 people, most of them paper-mill and textile workers, on the edge of the Cherokee National Forest. Etowah didn't get a hospital until 1965. Not surprisingly, when it was built. Woods was a spartan facility: the emergency room was open only during certain hours, and there was no intensive care unit. In fact, there wasn't an internist within 50 miles. Instead, family practitioners and general surgeons mended everything from sprained ankles to burst appendixes while cases of any complexity were referred to larger Bradley Memorial in the next county, the University of Tennessee Medical Center in Knoxville, or Erlanger Medical Center, in Chattanooga.

Still, Woods was healthy. In most hospitals back then in the fee-for-services days, just about anyone with a medical degree and a stethoscope could make money by patching up a patient and billing the patient's insurance company, few questions asked. In the late 1970s and early 1980s, the hospital, run by a retired air force colonel, added 40 beds to its original 30 and built an intensive care unit.

Then came the crunch. In 1983 the federal government stopped paying Medicare reimbursements based on a hospital's tally of the actual cost of the care given; instead, it began doling out flat fees based on its estimate of what the treatment of a given illness should cost. The payments were especially meager to rural hospitals, on the theory that a hospital's costs should be much lower outside a city. Woods's Medicare reimbursements plunged to less than 75% of the cost of treating its Medicare patients, who made up two-thirds of the hospital's patient population.

With its Medicare operations running deeply in the red, the hospital's cash reserves were soon depleted, leaving no money for improvements or even upkeep. Tile walls and floors began to crack. Patients waiting to be admitted sat in the lobby on folding chairs.

More important, the hospital couldn't afford to keep up with the latest medical technology. That, in turn, made it all but impossible to recruit young talent to the staff. One of the few doctors to join the staff in the late 1980s was Charles Cox, who had started at Woods as an orderly in 1976 before going to medical school and whose family owned a dairy farm in the area. ''There really wasn't much incentive for young doctors to come here,'' calls Cox, who would sometimes save patients during the day and do farm chores at night.

To make up for the reimbursement shortfall, the hospital tried raising its prices to non-Medicare patients. But that led to a leveling off of patients. It was clear that the only way to bridge the gap between Woods's costs and reimbursements was to reduce costs by improving efficiency.

Not an easy task. Inefficiency was ingrained in almost everything that went on at the hospital. Consider patient intake. Patients would wait 30 minutes or more in the dreary lobby while nurses filled in hospital admission forms and then typed hospital bracelets. If a patient needed blood work or X rays, a nurse had to fill in a three-page carbon-copy requisition form and hand-deliver copies to the lab and to billing.

Ah, billing: two women in a cramped office entering the charges for each patient into a bare-bones minicomputer-based system. and that was the high-tech part. They had to prepare the special forms for billing third parties, like Medicare and Blue Cross of Tennessee, by hand and then mail them. Four to six weeks later, when a batch of reimbursement checks came in, the switchboard operator would use the time between calls to record the payments in a 30-column ledger. ''Things moved slowly back then,'' says Carol Ethridge, chief financial officer and information officer. ''And because everything was done manually, there was plenty of room for error.''

When Phil Campbell arrived at Woods in 1990 to take over as CEO, the hospital was $200,000 shy of making its payroll and was struggling to survive. Campbell had been working as associate administrator of a health-care facility in Rome, Ga., when Woods's board hired him. ''I had wanted to go to a ''rural hospital,'' says Campbell. ''But I underestimated how difficult it would be.''

For the first few months, Campbell tried to persuade large suppliers to extend the small hospital's payment schedule. But then, suddenly, he took the offensive. Most hospitals charge for small items—a Band-Aid (as much as $10 in some hospitals) or a single aspirin (as much as $4 or more a pop). Campbell, who seemed determined to become the Crazy Eddie of health care, decided to give them away. Next he slashed prices on lab work, the hospital's biggest profit center. Then, as though the county board of trustees weren't already apoplectic, Campbell presented the group with an expanded budget that called for automating every last department of the small hospital. ''Oh, sure, some employees and citizens thought we were crazy,'' says Campbell. ''But I knew we had no choice.''

Campbell, a tall imposing figure with the middle-aged-boy looks of a high school football coach, knows he can come off as a little overbearing. ''My wife tells me I'm more conservative than Rush Limbaugh,'' he says, meaning it as a boast. If his administrative style seems somewhat military, it probably is. Campbell spent two years at the U.S. Army's Fort Stewart in Hinesville, Ga. But Campbell wasn't a soldier there; he was a student in a master's of health-services-administration program run by Central Michigan University. Alongside army colonels and majors, Campbell was drilled in the mantras of hard-core health-care management: Improve quality. Lower costs. Increase volume. Although he had studied health-care institutes in crisis, he faced the real thing for the first time when he took over at Woods. He was on the front line. And he admits to feeling green: ''There was nothing I could have done to prepare for this job.''

The single-level brick building looks more like a suburban elementary school than a hospital. In that respect Woods hasn't changed much from the day it was founded. Inside, though, it's a different story. To start, almost every inch of every surface has been redone—with carpet, paint, or wallpaper—in mellow lavender and mauve. A ''new'' Woods had to look the part. An interior designer chose the color scheme. Otherwise, each department was free to redecorate as it saw fit.

But the hospital's makeover was more than skin deep. Campbell knew that the heart of the transformation would be automation. The only problem was figuring out a way to afford it. The hospital had already solicited a bid from a computer vendor for an automation package; the bid came in at close to $1 million, about four times what the hospital could conceivably spend. Campbell got on the phone to see if he could do better. Exhorting vendors to cut corners and margins wherever possible, explaining that the old health-care gravy train had been derailed, Campbell finally got the proposal he

was looking for; an extensive new system for $250,000. That proposal came from Health Systems Resources Inc., in Atlanta. HSR agreed to install an IBM RS6000 and a UNIX-based work-station, along with 60 terminals and 12 PCs—enough to put every department in the hospital on-line.

Now all Campbell had to do was come up with a way to get the system to pay back. The key would be using the system to cut costs. Campbell divided the entire medical staff into small teams, each one with access to a PC and a mission—to examine a different element of the hospital's service with an eye toward reducing waste.

Take the pharmacy and therapeutics committee, headed by Brandon Watters, an internist. One of the committee's tasks: to assess the hospital's use of cephalosporins, a type of antibiotic. Harry Porter, a member of the committee and director of the pharmacy, called up records of what the hospital had been spending on antibiotics. It turned out that in the previous year, Woods's use of all cephalosporins had gone up 204%, mainly because its use of Rocephin, the most expensive antibiotic, had gone up. So Porter, who documents the use of all drugs in the hospital, had the computer graph the applications of Rocephin. The chart revealed that 70% of the time the powerful antibiotic was dispensed to treat infection but that 30% of the time it was administered to prevent infection in patients undergoing surgery.

After a bit of research the committee determined that far less expensive (but equally effective) antibiotics could be substituted for the surgical use of Rocephin. The result; an estimated $40,000 savings on Rocephin in 1995. To keep the medical staff up to date with his committee's findings, Watters imports all of his results from Quattro Pro into Microsoft Publisher, which he then uses to publish *inPHARMation,* the hospital's pharmacy and therapeutics newsletter.

Food waste was another target. Thanks to the dietary and food-services committee headed by Michele Fleming, director of food and nutrition services, Woods now uses a PC spreadsheet to track virtually every aspect of food service, from patient's satisfaction with portion size to seasoning preferences. As a result, patients are less likely to end up with food they don't like and won't eat. Fleming knew, for example, that in the second quarter of 1995, only 92% of patients said they received the correct seasoning packets with their food. By the fourth quarter the number was up to 100%.

To save nurses and administrative employees time, the new system streamlined the laborious admissions process. Today patients zip from the lobby to their hospital bed in minutes. With just a few keystrokes, an admissions clerk enters a new patient's record into the system and instantly creates an electronic billing form on the main server. The clerk then hits another button to print out an embossed plastic identification card on a special printer. Using an imprint of the card, the clerk can also quickly manufacture a plastic hospital ID bracelet. Because billing and accounting have been integrated into the system, patient charges and insurance bills are tallied electronically during the patient's stay.

Gone, too, are the days of carbon-copy requisition forms. Now nurses simply order lab work and diagnostic images through the computer system. In addition, lab equipment has been electronically connected to the mainframe. Now Cindy Glaze, supervisor of the laboratory, can transfer blood-test results from her lab instruments to her computer terminal and then, with a keystroke, on to the emergency room, the operating room, or a nursing station.

Automation has all but eliminated some of the worst administrative chores. When a nurse electronically orders 500 ccs of erythromycin from the pharmacy for a patient, the system automatically charges the patient's billing record. It used to take weeks for the hospital to finalize patients' bills; today bills are ready whenever patients are ready to leave the hospital. And no one fills in forms by hand or licks envelopes and mails them off to Blue Cross or Medicare; instead, charges are automatically transferred to the proper electronic form, and then, using a dial-up account, a bill is transmitted to the third-party payer. Ethridge says that reimbursement takes about 14 days.

As for the new switchboard operator, Virginia Huff, she rests easier knowing that the computer takes care of the Medicare logs. When a doctor orders an MRI for an elderly patient, the charge automatically transfers to an electronic log. Running the log for the entire year takes just a couple of hours of computer processing time.

Campbell's plan has worked. Not only have Wood's outpatient utilization rates increased by 25%, but the hospital's net income has nearly doubled in the past five years. Last year outpatient utilization rates actually surpassed inpatient rates—which means higher revenues because insurance companies typically reimburse outpatient procedures at a higher rate. After Campbell dropped the prices of lab work, the volume of work in the small lab increases dramatically—300,000 tests in 1995, up from 115,000 in 1991. Remarkably the hospital has not raised the prices of care in five years, nor has Campbell added any clerical positions to the staff, even with all the increased billing. ''If we were still keying in bills, we would need at least twice as many people in the billing department alone,'' says Ethridge.

Fewer nonmedical positions means more dollars to recruit doctors—a critical goal. The average can general $1 million in revenues for the hospital annually. Woods uses some of the freed-up money to pay for new recruits' medical education in exchange for a commitment to practice there. The difference in the opportunities for young doctors today and in 1988, when he joined the hospital, is huge, says Cox. ''Today we have all the technology that big urban medical centers have. So doctors can come here and not feel at a disadvantage.''

Active recruitment efforts along with a healthy cash surplus have allowed Woods to expand services. For example, Campbell hired Dan Early to direct the new Resource Counseling Center. In addition, to reach African Americans in the county (a population that traditionally has had trouble accessing health care), Campbell founded the Minority Health Alliance for education and care.

Recently the University of Tennessee Medical Center in Knoxville chose Woods as one of its first partners in its telemedicine program, which allows doctors to work via videoconferencing hookups. Woods's telemedicine facility is located in what used to be the gift shop. So far the state-of-the-art satellite link has been used primarily for dermatology. But doctors can also keep up to date with the medical advances at U.T. without leaving Etowah. Craig Riley, for example, an internist, attends live conferences at U.T. via satellite and can even use the live link to complete the continuing medical education credits he needs to meet Woods's credit requirements.

As Woods moves into a new era of health care, Campbell continues to position the small hospital for aggressive growth. Last year Woods joined Galaxy Health Alliance, in Chattanooga, a managed-care network of 13 rural and suburban hospitals in four states. (Woods is also part of another managed-care network that includes U.T.) Although managed care may represent a controversial new road for medicine, few hospitals want to be left out of the loop. An Zuvekas, senior research staff scientist at the Center for Health Policy Research at George Washington University Medical Center, in Washington, D.C., predicts that rural hospitals increasingly are going to depend on advanced electronic networks for their survival. She reasons that it's more effective for managed-care plans to interact just once with a group of hospitals than to deal with them individually; consequently, says Zuvekas, rural hospitals that are able to share both data and expertise over a wire are going to distinguish themselves as worthy partners in the managed-care relationship.

The road ahead is filled with uncertainty. Potential Medicare cuts could make it even more difficult for rural hospitals to make ends meet, and managed care might force many more hospital mergers and acquisitions. Still, Campbell has a grand outlook for Woods. On a tour of the hospital, he points out the window to a mound of dirt. ''That will be a state-of-the-art women's center,'' he says. ''We are finally going to start delivering babies again.'' A nearby parking lot will soon be transformed into an expanded intensive care unit and emergency room, he adds.

Ethridge, meanwhile, is just trying to enjoy the fact that for once Woods isn't struggling. ''We've been waiting six years to slow down,'' she says. Given Campbell's ambitions, Ethridge probably shouldn't plan on too long of a lull.

SUPPORT THE FEDERAL PROCUREMENT SYSTEM

HON. WILLIAM H. ZELIFF, JR.

OF NEW HAMPSHIRE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 31, 1996

Mr. ZELIFF. Mr. Speaker, I am introducing a bill today which will foster the continued participation of small business in the Federal Government's procurement system.

During my tenure in Congress, I have been closely involved in the procurement reform debate. As a member of the key committees of jurisdiction over this issue, Government Reform and Oversight and Small Business, and in my own experience as a small businessman, I know the importance of the small business community in Federal procurement.

Small business is vital to this Nation's economic success. And with enactment of the Federal Acquisition Reform Act, which I strongly supported, Congress created a newly reformed, streamlined procurement system designed to assist all businesses.

Although recently, agency actions have limited small business participation as prime contractors in the procurement process by inappropriately bundling contract requirements in order to decrease the number of contracts an agency must manage. Government agencies have argued that by bundling these contract requirements, it is simply much easier for them to do their job because they only have to deal with one or two vendors instead of hundreds.

Working with only one or two vendors as opposed to working with hundreds of suppliers may be easier for agencies, but limiting Federal contract opportunities to only a few companies on a few contracts, is unfair to small businesses. Not only is this practice unfair, it eliminates built-in competition in the Federal