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The bright, on-line future is coming in five-day bites

Internet, call centers, HIPAA aftershocks due

The problem with a five-year projection on the state of health care access management, says **Jack Duffy**, FHFMA, is that the industry may have gone through "five or six complete changes of technology and knowledge" by that time.

"We used to think about progress in five-year bites," adds Duffy, director and founder of Integrated Revenue Management in Carlsbad, CA, and *Hospital Access Management's* consulting editor. "Now we talk about progress in five-day bites."

One prediction Duffy makes with relative certainty, he says, is that 100% of patient information will be accessed through the Internet and that information will be maintained by the individual patient or beneficiary on his or her personal web site.

Other access futurists who shared their thoughts with *HAM* see a major impact from the Health Insurance Portability and Accountability Act (HIPAA) of 1996, smaller admitting departments, clinical advances driving changes in access strategies, and more employees working from home,

Repeal of OSHA rule takes pressure off AMs

The repeal of the Occupational Safety and Health Administration's (OSHA) ergonomics regulation in March takes the pressure off the health care industry — and nearly every other industry in the country — to put in place programs aimed at reducing workplace injuries.

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COMING IN FUTURE ISSUES

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among other predictions.

In contrast to the great lengths that health care providers historically have gone to define and redefine every patient encounter, Duffy suggests, providers of the future will get a one-time use key for the patient's information when a service is needed. "It will be like a hotel room where you get a plastic key that's reprogrammed every time a room is used."

The master person indexes that health care organizations are struggling to perfect will go away, Duffy predicts, as consumers become adept at maintaining their own web-based information. In the meantime, he says, there likely will be some "transitory technology," such as a resurgence of the community health information networks (CHINs) that the federal government funded in the late '80s and early '90s.

These CHINS — which faded from sight after the funding ended — might be reincarnated to serve as nonproprietary repositories of key pieces of data for an entire community, Duffy says. They would hold not only demographic information, but data on drug interactions and patients' histories and physicals, he adds. "While building out the access to the Internet, we could use this community network as a place holder."

The future goes overseas

In the access department of the future, he says, most of the "heavy work" — the gathering of the initial data set — will be moved to a call center and will be done prior to service. And there's a better-than-even chance, Duffy adds, that the call center will not be in the United States.

Commercial call centers for other industries, he says, have moved to Ireland, then to India, in search of large English-speaking populations and access to lots of labor. "It's happening right now and it will continue to happen." Although as far as he knows, that hasn't happened yet with health care call centers, Duffy adds, it is just a matter of time. There are more than 100 companies in India doing medical transcription and/or coding, he points out.

There will continue to be patients who access the health care system without being scheduled and will need to be validated, Duffy notes, but the process will be "100% electronic. Databases will be accessed electronically, not by telephone."

As a result, the access department itself will be "concierge-oriented," focusing on customer service and serving — through the emergency

department — as a backup to the main procedures, he says.

The biggest factor in future health care access management will be the effects of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, contends **Debra Hubers**, interim CEO of Del Mar, CA-based MedCambio, a health care payment network that aims to provide point-of-service claims adjudication for its provider clients.

Standardization is overdue

Although HIPAA is the source of much angst and argument within the health care industry because of the expense of implementation, the standardization it calls for is "15 years overdue," Hubers says. "Health care is one of the last industries to adopt standardization within data exchange. We've been debating this way too long with ANSI [American National Standards Institute in Washington, DC], and it's time to come up with an agreement on the standard exchange of [electronic] data."

The same issue was handled a long time ago in the financial industry, she points out, which is why the average financial transaction for a merchant is about eight seconds. "The only reason they can do that is because they have standards related to security and the exchange of confidential information."

HIPAA is crucial to that happening in health care, Hubers notes, because it provides the rules for the infrastructure that must be created.

"It neutralizes the parties," she says. "CHINs didn't work because too many people wanted to maintain their position in the market. HIPAA is universal; it's a mandate by the government. Some things are appropriate for the government to mandate, and standards for the movement of data are one thing the government has done well. The highest number of electronic submission of claims happens in the Medicare and Medicaid arenas."

Accompanying the changes prompted by HIPAA, Hubers suggests, will be a more efficient admitting department. "The people in admissions will be related more to patient care instead of administration and chasing paper," she adds. "There will be better community relations. With obligations known at the time of service, the whole process will be more efficient."

The data collection and processing side of health care will become less labor-intensive, agrees **Peter A. Kraus**, CHAM, business analyst for patient accounts services at Emory University Hospital in Atlanta, but says the confidentiality and privacy rules of HIPAA could slow progress in that area to some extent.

"Eventually, we'll find HIPAA-approved ways to obtain demographic, financial, and clinical patient data," he adds. "Maybe it will be on a chip-laden health care card or reside somewhere out in cyberspace. We can't discount the potential influence of web-based technology on the role access departments play in the health care scheme."

With less billing and collection work necessary, he notes, "I'd like to think that customer-service-oriented programs will fill the void. Patients certainly appreciate hotel-like amenities, and there's plenty of work to be done to integrate the continuum-of-care model.

"But if cost-containment programs run rampant," Kraus adds, "service could become quite basic. It's hard to say what health care customers will tolerate when faced with affordability decisions."

Access management is likely to move beyond the realm of health care — perhaps to the airline and hotel industries — to find innovative methods to aid in securing patient demographic, financial, insurance, and medical information, notes **John Woerly**, RHIA, MSA, CHAM, an Indianapolis-based manager with Cap Gemini Ernst & Young.

Although computer systems will support the bulk of those needs, Woerly points out, "we cannot underestimate the importance of 'people' and 'process' to enhance the outcome of technology."

"The blending of people, process, and technology," he emphasizes, "will ensure data integrity while promoting a seamless customer experience. All three must be in balance to be successful."

Like Duffy, Woerly predicts that traditional, stand-alone patient access departments will become a thing of the past. "Enterprisewide patient access models will emerge, utilizing customer relationship management / call center infrastructures to serve all populations."

Reacting to clinical change

Many of the innovations in access management that occur in the next five or 10 years will be in response to changes occurring on the clinical side of health care, points out **Barbara Wegner**, CHAM, regional director of access services for Providence Health System in Portland, OR.

Because the field of nursing, for example, is not attracting young people in large-enough numbers,

Wegner says, there is a shortage of nurses that likely will become even more of an issue in the future. Access personnel may have to determine what they can do to help fill the void, she suggests.

"Nursing isn't 100% clinical," Wegner notes. "There are a number of duties and functions — utilization review, giving out managed care letters, making sure patients understand their rights and responsibilities, as with advance directives — that aren't actually clinical." Those tasks may have to be looked at, she adds, with an eye on having access share the load.

Fewer hospitalizations

The same situation exists with health care technicians, Wegner says. "I'm not sure how that shortage might impact us, but there may be things they do, like entering orders, that access [can help with] as people come to the table and start reengineering."

Advances in medical technology, she predicts, will reduce the number of people needing hospitalization and make their stays shorter. Innovations like bloodless surgery "might remove the need for acute care," Wegner suggests. Those changes will impact how many people need to be registered and how they will be seen, she adds, with more outpatient visits and home visits in place of inpatient care.

"In the very near future," Wegner says, "people are going to be able to use an inhalant for insulin, instead of injecting it. That will change the number of people who are hospitalized for diabetes. In the area of orthopedics, there will be a substance in a tube that can be injected into the bone when people break an ankle. It will strengthen the bone right there so people can walk out of the emergency department."

Access departments will need to re-engineer their processes to fit these changes in technology, she notes. "We live in a world of change; so every day, we have to look at what we're doing and be prepared to make changes."

The one thing that will continue to be paramount, Wegner emphasizes, is that access representatives do a high-quality registration the first time, so hospitals and health care systems can get maximum reimbursement without rework needed on the back end.

"That won't change, but a lot of other things will, she says. "We'll continue to change our processes, but that will remain our No. 1 objective." ■

If you think collecting is hard now . . . look out

'Fixed benefit' possible

Health care providers may experience a very unwelcome change in the near future if they don't make it easier for patients to access care, warns **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management in Carlsbad, CA.

Under the federal Employee Retirement Income Security Act of 1974, Duffy points out, insurance coverage for employees is voluntary, and employers have the ability to go to a "defined contribution" benefit plan.

Under such a plan, he explains, employers provide a fixed benefit amount, and employees have to go out and buy their own insurance. **(See related story, p. 53.)**

"If we as an industry persist in making it so difficult to use our service, we shouldn't be surprised if employers withdraw [from providing insurance coverage]," Duffy says. "If we have trouble collecting copays, just think what trouble it would be if we had to collect [entire] balances."

Choosing satisfaction

Employers spend more and more money chasing satisfaction with health care coverage, which is ever elusive, he notes. They may begin to ask themselves, Duffy says, "Why should I put $800 a month into a health care benefit, only to be told daily that it's the biggest source of [employee] complaints?"

For years, he adds, health care providers have enjoyed the reputation of being more difficult to use than any other service provider in the community. "It shows up every time we poll our populations.

"We have a universal spot in our heart for the failed transaction," Duffy contends. "We tend to discount that, ignore it. When you put [hospital] bad debt on your credit report, the general view — including lending officers — is that the health care industry is so bad at this that a medical debt that failed won't count against you. Everybody's got them.

"A rational person," he continues, "would not condemn valued customers to 12 months of suffering, trying to [determine] the relationship between

their portion of the cost and that of the insurance while failing to explain how they work together."

This scenario between registrar and patient, Duffy suggests, reflects the current situation:

Registrar: "Did you read your policy?"

Patient: "No. Did you?"

Registrar: "No, but you're sick and I'm not."

'Eliminate the pain'

What consumers would celebrate is a recognition of the deficiencies in the current way of doing business and a dedication industrywide to correct those deficiencies, Duffy says, "so that patients don't have to struggle for months and years after a health care event just to handle the basic function of payment.

"We don't want to optimize a transaction which is in general viewed by our customers as onerous," he adds. "We don't want to make it better pain. We want to eliminate the pain."

It's important, Duffy stresses, for access managers to participate in, perhaps initiate, discussions on removing what some call the hassle factor of health care. Even many of the chief financial officers and chief executive officers he meets with, he says, are amazingly unaware of what makes a good access department and why its function is crucial to the institution's financial well-being.

"They've never matured," he adds. "They're still judging the quality of their access departments by the length of the line. [The thinking] is still very primitive at their level." ■

Interest reported up in defined contribution

As health care costs continue to climb, employers are showing increased interest in defined contribution plans but have yet to fully embrace the concept, the Washington, DC-based Employee Benefit Research Institute reports.

One reason for the employers' hesitation is the tight labor market, the report finds. It cites three main reasons why employers are considering some sort of defined contribution health benefit: cutting cost, backlash against managed care plans, and giving workers more choice and control over their benefits.

The report, "Defined Contribution Health Benefits," can be ordered by calling (202) 775-9132. ■

Baycare's customers eager to use Internet

E-mail use speeds customer service

Like a growing number of health care systems across the country, Clearwater, FL-based Baycare Health is looking to the Internet to help define the future of access management, says **Martine Saber**, CHAM, regional project manager for patient access services, and has found that its customers are more than ready to come on-line.

"We had a focus group of patients and said, 'How can we serve you better?'" Saber adds. "You wouldn't believe how many said, 'We want to do business on the Internet.'"

Privacy concerns

While Baycare officials had expected privacy concerns about the Internet to be an issue with their patients — many of whom are senior citizens — that notion was quickly dispelled, she says. "They laughed and said, 'I do banking and stock trading on the Internet; and if that's secure enough, I can certainly [register for a hospital stay].'"

With that vote of approval, Saber says, Baycare is building a web site. It will begin by registering obstetrics patients on-line, as other health care organizations have done **(see *Hospital Access Management*, January 2001, p. 7)**, and will gradually include its other patient populations, she adds.

Customers now are given an e-mail address where they can send questions about their bills instead of calling the customer service department, Saber notes. "That [usage] has really picked up. Staff are able to respond so much quicker than by phone and we have gotten good reviews from patients."

Baycare is giving physicians access through the web to patients' medical information and test results, she points out, as well as to any type of demographic information. "They used to have to wait for us to give them a fact sheet."

Registrars are getting insurance verification and authorization of patient accounts via the Internet, Saber says. "All of our insurers are getting on the bandwagon. We [obtain benefit information] through the web instead of a phone call."

To facilitate the use of the Internet, she adds,

Repeal of OSHA rule takes pressure off AMs

(Continued from cover)

The rules sought to make corporations focus far more on addressing the most common workplace injuries in the nation, including repetitive stress injuries such as carpal tunnel syndrome. The condition typically affects workers — including access personnel — who use computers. Access managers were expected to be heavily involved in implementing programs in response to the OSHA rule, which be came effective in January.

The sweeping regulation met with a partisan defeat in Congress.

Labor Secretary Elaine Chao has said she intends to pursue a comprehensive approach to ergonomics that may include new rule-making.

When OSHA, a branch of the Department of Labor, issued the rules in November, it said they would cost $4.5 billion to implement, but would save businesses $9 billion a year in increased productivity and fewer sick days. Sen. Don Nickles of Oklahoma, the Republican whip and sponsor of the repeal effort, called the OSHA estimates "hogwash," insisting the rules would cost far more to implement than they would save. ■

staff are being retrained to do Windows-based rather than mainframe computing. "Our newest version of [Malvern, PA-based] SMS software is Windows-based."

The future of referrals

Baycare is encouraging its physicians to participate, which they can do simply by calling the insurance company, signing up, and obtaining a password, Saber says. However, many physician offices still do not use computers, she points out. Those who do, and take advantage of the insurance companies' web sites, can handle their referrals over the Internet, Saber adds. "They don't have to call the insurance company or the [other] physician's office to get authorization." ■

Baycare takes scalpel to its insurance master

System streamlines for transition to CBO

With the ultimate plan of transitioning to a central business office (CBO) for its 10 hospitals, Baycare Health in Clearwater, FL, has taken on the task of standardizing the insurance masters throughout the system, says **Martine Saber**, CHAM, regional project manager for patient access services.

Previously a three-hospital system, Baycare merged with seven other hospitals four years ago, Saber explains, and each facility has its own insurance master. "Every one is different," she adds. "One has less than 100 insurance plan codes, and another has 2,600 plan codes."

The goal is to find the best practice — from among its own hospitals or from researching processes at other organizations — and to standardize the procedure for choosing a plan, Saber says. Eventually, she adds, the entire system will go to one billing method.

"Even though we're merged, we have separate databases," she points out. "Eventually, they will look the same, but they will remain separate."

Although patient access personnel began working on the project alone, she notes, they quickly realized the importance of including their colleagues in patient accounting and in the system's managed care department.

"At first, we were only looking at what would make it easier for us, but then we said, 'No, we might delete plan codes and cause chaos [with managed care contracts] or create more work for the back end,'" Saber adds. "About 60% of our business is managed care."

Baycare formed a multidisciplinary task force of 26, with representatives from all 10 hospitals, she says, and broke up into smaller groups to tackle individual projects. "The neat thing is that the [access] people on the team are actually registrars that do this every day, instead of managers or directors."

Patient access has the job of evaluating and revamping the way the insurance plans are named, while patient accounting is looking at changing the numbering conventions, Saber says. "Our first priority is to make it user-friendly for the registrar."

The largest number of errors, she notes, were

due to choosing the wrong plan code — not choosing Cigna instead of Aetna, but choosing Cigna PPO (preferred provider organization) when the patient actually has Cigna HMO. The difficulty, Saber says, has been that insurance cards "don't always tell you the product line" — whether it's a PPO or an HMO — or that they list all the plans and "you don't know which one to use."

Another complication: With the backlash against managed care, insurance companies keep changing the names of their plans, she adds, "taking the 'HMO' and 'PPO' off the card. Registrars are faced with having to remember which product is which to choose the right plan code."

Under the new system, Saber says, the name in the insurance master will be the name on the card. "It won't say 'United HMO,' it will say 'United Choice Plus.'" A naming convention is being created, she adds, so that all Medicare products will start with "MCR," all Medicaid plans with "MCD," workers compensation insurance plans with "WC," and so on.

The patient access team also is looking at discrepancies in the insurance masters at the various hospitals, Saber notes. "Why does one insurance master have one Cigna plan code, and another has 25 Cigna plan codes?" The new rule, she says, is "if anything is used less than 100 times in a year, get rid of it." Otherwise, the insurance master is so big that it's too hard for registrars to identify the right plan code, Saber adds.

On the other hand, for hospitals whose insurance masters have less than 100 codes, more will be added, she explains. At those smaller hospitals, Saber says, the insurance master was simpler, but information that was automated at the larger hospitals had to be typed in. "That was extra work," she notes. "Registrars had to touch every plan code before it was billed."

Compromise is key

At one hospital, there were only a few Blue Cross plan codes, she says, while another had more than 300 Blue Cross (BC) codes. "We said that if Hospital A can appropriately bill using a minimal number of BC plan codes, then we would go with their process," Saber adds. "But it turned out that even though Hospital A had a limited number of plan codes, its patient accounting employees were doing a lot of rework on the back end."

On the other hand, at Hospital B, the bills were going to the right place, she says, but registrars were making errors because it is difficult to choose the right plan code with so many to choose from. "We compromised," Saber adds. "We reviewed each BC plan code and deleted some from Hospital A, added some to Hospital A and used Hospital B's billing process."

The rule has become that a procedure is kept if it "creates a little work on the back end, but decreases a lot of errors on the front end," Saber adds. If the reverse is true, the procedure goes, she says.

In addition to eliminating plan codes that are used infrequently, she explains, the team is able to get rid of others that were put in according to the employer associated with the code. For example, the insurance masters included United plan codes that all had the same address and contractual information, Saber says, "but said, 'Use this one for a specific employer.'"

The initial thought had been that would make the process easier for registrars, but instead it made it harder, she adds, because the system was so cumbersome. "Now we reduced those 20 plan codes down to one, no matter who the employer is."

To keep the insurance masters streamlined, Saber says, the system will run a usage report every year and throw out the superfluous codes. "We've promised ourselves we'll never get to this point again."

To help registrars choose the right plan code, "help comments" are being added to the insurance screens. The tip might be, for example, "With this plan code, the policy number always begins with an 'R,'" Saber says.

One of the missions of the patient accounting team, meanwhile, is to make sense of the numbers that are assigned to the various plans. "We never had a rhyme or reason before to how the numbering was done," she notes. To remedy that, the team may designate, for instance, that HMOs will be numbered 0-10, PPOs 10-20, and so on, Saber says. "When we checked around the country as to how people were doing it, this is what we found."

The team also is looking at differences in billing among the Baycare hospitals — why one facility, for example, uses two insurance codes where another uses one, she notes. "We find the best practice and do it that way."

One hospital had separate plan codes for Medicaid inpatients and outpatients, Saber says. "We didn't have that at any other hospital. It had something to do with the way the managed care system was taking the [contractual information].

"It turned out this hospital could do what the

other nine hospitals could," she adds. "We challenge each other that way."

[Baycare Health continues to refine its insurance masters and welcomes comments from peer organizations that have a better way of doing things, Saber says. She can be reached at (727) 462-7139 or by e-mail at martine.saber@baycare.org.] ■

AM takes part in 'fun piece' of job

Staff do 'rapid design' of new hospital

In this era of vanishing bottom lines in health care, it's rare to hear of a hospital embarking upon a major building project. That's exactly what Salem (OR) Hospital is doing, however, and it's one of the reasons admitting manager **Charlene Overfield**, RN, CHAM, decided to come on board last year.

With much of the access arena consumed with shrinking reimbursement and burdensome government regulation, she notes, it's nice to be part of the "fun piece" of the business. One of the most intriguing parts of the design phase, Overfield says, was an evening when hospital personnel gathered to do a "rapid design" of their new facility.

Building a hospital

Hospital managers, directors, physicians, and administrators came together, under the direction of project consultants and architects, and were broken into three groups, Overfield explains. "They tried to put enough people in each group to represent clinical, administrative, financial, and physician [viewpoints]."

The groups were given cards representing the various departments in a typical hospital. The bigger the department in terms of square feet, the more cards were allocated to represent it, Overfield says. "They said, 'We want each of you to build a hospital, placing the cards horizontally as well as vertically, and thinking 10 years out!"

Each card represented so much square footage, so there were five or six cards for surgery used to represent a surgical suite, recovery room, and so forth, she notes. Participants talked about how the needs of various departments had changed or would change in the next five to 10 years."It was really fun to design a new facility," she says, "not only what should be on the first floor, but what makes sense to be adjacent or on top of that. It was very interesting to see what each group came up with."

It was interesting, Overfield adds, to see the emergency department (ED) physicians and the psychiatrists, for example, jockey for position. "They talked about how much space they needed, what they wanted to be next to, and remember, this is for five or 10 years from now. They had to look at, 'How is your medical practice going to change?' and 'How will new technology change the way you're dealing with patient care?'

"ED people were saying they needed to be close to new scanning equipment, and to surgery, and to an elevator devoted to the transporting of patients," she says. "They also wanted to be next to the angioplasty department. They get so many cardiac patients, and with the new technology, felt [patients] could go from a heart attack to the angio room."

The architects and consultants chose the best plan from among the three groups, Overfield says, and participants then dissected that proposal, suggesting changes. "That's what the architects used to plan [their design]."

The people at that initial rapid-design session were put on one of four different design teams, representing patient support, emergency department, mother/baby services, and a steering committee, she notes. Those teams meet monthly to continue to fine-tune the hospital design.

Overfield is on the patient support team, but also has sat in with the ED design team.

The admissions department traditionally has been part of "the front door" of the hospital, and that needs to be maintained, she says, but there has been discussion of how the admitting space may be modified because of changes in operations.

"We talked about bringing much of the outpatient scheduling, insurance verification, and authorization to the front end, so we're looking at more preregistration, scheduling, and financial counseling space," Overfield notes. "We're also looking at having a point of service where we register everyone, and then have the departments [where the patient receives a service] activate the account. The patient will wait there. Our goal is to have more than 90% of patients preregistered."

That means, she says, that while in the past there has been more lobby space in the admitting area, the new design may focus on having more space in the various ancillary departments.

Salem has a number of distinguishing characteristics that figure into the design challenge, Overfield points out. It is the capital of Oregon, with a population of about 150,000 — 200,000 including surrounding areas. Salem Hospital is the city's only hospital, as compared to Portland, which is 50 miles away and has a whole group of hospitals.

"Some departments are totally overtaxed," Overfield says. "With 250 patients a day, we have one of the largest EDs in the state as far as volume is concerned. Every piece of real estate is taxed, and [the ED] is very busy and very crowded."

Salem Hospital is licensed for about 460 beds, and sees about 18,000 patients a month, she adds.

Because downtown Salem has a number of skybridges, which are part of the atmosphere of the community, they are part of the existing hospital campus and will be used in the design of the new facility as well, Overfield notes. Site preparation will begin in the spring, she adds, but it will be more than three years before any departments actually will occupy the new hospital. ■

It's the facts that count in EMTALA cases

Avoid 'knee-jerk' response, expert says

A decision earlier this year in an Emergency Medical Treatment and Active Labor Act (EMTALA) lawsuit is important because it shows that every case ultimately depends on whether the facts hold up, says **Stephen A. Frew**, a Rockford, IL, health care lawyer who advises hospitals on the 1986 law.

The decision should serve as a reminder to health care providers that they should not make the "knee-jerk assumption" that just because the law applies in a particular case, liability will attach, Frew says.

In the case, *Roberts vs. Galen of Virginia Inc.*, a federal jury decided that a hospital did not violate EMTALA when it sent a patient to a nursing home and her condition subsequently deteriorated. The hospital transferred the patient to a nursing home after an emergency admission and a six-week stay.

In one of the first tests of the law in a trial by jury, the U.S. District Court for the Western District of Kentucky ruled in favor of the defendant, a hospital operating under the name of Galen of Virginia Inc., and against the plaintiff, who was the guardian of the patient.

There have been few EMTALA cases that have reached verdict, Frew notes, and most of the rulings until now have been on legal interpretations of the law. In January 1999, for example, the Supreme Court held in *Roberts vs. Galen* (119 S. Ct. 685 1999) that patients who claim to have been dumped in violation of EMTALA — the anti-dumping statute — need not prove that the hospital acted with an improper motive. That holding left physicians, hospitals, and attorneys wondering about its implications for federal malpractice cases arising under EMTALA.

The U.S. Supreme Court remanded the case back to the District Court after appeal through the U.S. Court of Appeals for the 6th Circuit.

In the recent decision, Frew points out, the jury found that the plaintiff failed to establish that the patient was inadequately stabilized before movement. "This goes back to the ultimate issue, that every case is ultimately decided on individual merits," he says. "Just because the court rules that EMTALA applies, the sky is not falling. Yes, the [plaintiffs] alleged enough to justify [trying the case]. They just couldn't prove it."

How to view a violation

Some rulings produce a "hysterical reaction on the part of hospitals and medical providers who up until now hadn't been paying attention," he says. It's important to consider the rulings, but not until a case is decided completely, he emphasizes. "Interim decisions are not necessarily going to define the law."

On the other hand, Frew notes, hospitals should be aware that just because a jury finds there is no EMTALA violation, that doesn't mean the Health Care Financing Administration (HCFA) won't enforce a violation in an administrative context.

"There is a lot of confusion between what the courts do and what HCFA does," he adds, pointing out that HCFA regulations "mirror the general provisions of EMTALA and provide more extensive and more quality-oriented standards.

"My personal view," Frew says, "is that hospitals have insurance for lawsuits, but they don't have insurance for administrative citations. So while [EMTALA cases] are certainly an issue, let the insurance companies worry about the courts and the health care providers concentrate on complying with HCFA."

(More information on EMTALA issues is available on Frew's web site at www.medlaw.com.) ■

JCAHO turns focus to continuum of care

Patient privacy a priority

If you get a visit from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) this year, it's likely the surveyors will focus more on the continuum of care for an individual patient and less on an assortment of records and departmental issues.

Although the JCAHO's 2001 survey process hasn't changed dramatically from past years, "it will focus on individual-centered evaluation," says **Charlene Hill**, a spokeswoman for the Oakbrook Terrace, IL-based organization. "Rather than looking at care rendered to a variety of patients, [surveyors] will select a patient to follow through the entire system, so they can see the full continuum of care."

That was the case for Boston's Brigham & Women's Hospital, which was surveyed in February, notes **Christine Collins**, CHAM, director of patient access services. "They were much more interested in the continuum of care and the interdisciplinary, and didn't focus on one department."

JCAHO surveyors looked at patient rights' issues such as advance care directives, asking, for example, how those were followed up on in the nursing units, Collins adds. "They followed a patient from the emergency department (ED) to the room."

Rather than addressing "admitting for admitting's sake," she says, the surveyors met with all the hospital's directors to get a broad-based impression of patient care, and gave the directors high marks. "They were impressed with the group, felt that we understood what we were here for, and liked that we didn't have a script but were very honest and forthright."

The survey team asked "lots of questions about confidentiality," Collins adds. "They were very concerned about making sure privacy and patient confidentiality were a priority" and also wanted to see documentation of patient education and interpreter services, she says.

As expected, the surveyors did make an "off-hours" visit, Collins explains, arriving at the ED in the evening and moving with a patient through the operating room and on to the nursing floor. "It was much more hands-on, out and around" than in previous years, with less time spent talking in rooms.

The surveyors questioned different managers on fire doors and evacuation plans, Collins notes. "They checked out oxygen cylinders, and whether equipment was in designated areas and linen carts were kept closed."

Documentation of quality improvement initiatives was another area of interest, she adds, as was staff competency. "They were stopping people for interviews and asking, 'How do you know your staff are competent, at all levels?'"

Brigham & Women's was "more than satisfied" with its review process and "delighted to have passed," Collins says. One area of suggested improvement was in providing speedier job reviews for staff, she notes, which was not a surprise at a facility that has been over 100% occupancy for more than a year.

"They know we do great things here," Collins adds. "It's more their style now not to find what's wrong, but just to point out things you need to improve on." ■

Standards added for patient safety

Education, rights emphasized

Earlier this year, the board of commissioners of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approved new standards directly focused on patient safety and medical/health care error reduction in hospitals, notes **Charlene Hill**, a spokeswoman for the organization.

Those standards focus, among other things, on emphasizing patient rights and the education of patients and their families, responsibilities that typically fall to the access services department.

The new standards, which have an expected implementation date of July 2001, Hill says, augment the nearly 50% of existing JCAHO standards related to patient safety.

Requirements for establishing ongoing patient safety programs will be added in these standards areas:

- **Leadership.**

Hospital leaders are to create an environment that encourages error identification and remedial steps to reduce the likelihood of future, recurring errors. Such an environment includes minimization of individual blame or retribution for those

involved in an error or in reporting an error.

• **Improving organization performance.**

Hospitals are to implement a program for proactive — before an error has occurred — assessment of high-risk activities related to patient safety and to undertake appropriate improvements.

• **Management of information.**

Hospitals are to aggregate patient safety-related data and information to identify risk to patients, apply knowledge-based information to reduce these risks, and effectively communicate among all caregivers and others involved in patient safety to guide and improve professional and organizational performance.

• **Other functions.**

Hospitals are to place appropriate emphasis on patient safety in areas such as patient rights, education of patients and their families, continuity of care, and management of human resources. The standards state that the patient and/or the patient's family is informed about the results of care, including unanticipated outcomes.

In developing the standards, Hill says, the JCAHO sought advice from a panel that included patient safety and medical/health care error reduction leaders, as well as representatives from government, hospitals, insurance companies, universities, and advocacy groups.

The standards have been posted on the JCAHO web site, www.jcaho.org, for public comment since last summer. ■

Patients, visitors can use 'eKiosks' in waiting area

Hospital's web site featured too

Provena Saint Joseph Medical Center in Joliet, IL, is placing two eKiosks, stand-alone Internet workstations, in its main lobby and outpatient admissions area. The eKiosks will feature wireless, high-speed broadband connectivity and will allow users to perform various computer tasks.

"We are excited about what this means to our patients and visitors," says **Lisa Lagger**, Provena spokeswoman. Businesspeople can use the eKiosks to connect to their offices, younger people can use them for research and homework. "It's going to be a terrific asset to our patients and their families and visitors."

Provena signed a three-year agreement with eKiosk of New Lenox, IL, developer of the workstations. Health care is a new arena for eKiosk, which had previously focused on the hospitality and airline industries. "I envision this [venture] to be like the more sophisticated airport lounges that are consumer-focused," Lagger says.

These workstations are the pay phones of the 21st century, says **John Bohrer**, eKiosk's vice president of its health care division. The eKiosks have both phone lines and a variety of ports, such as USB, RJ-11 modem, RJ-45 data, and infrared, that can connect laptops, notebooks, palmtops, and other handheld devices to the Internet.

The company also recently acquired technology,

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Editorial Questions

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called "MyID," that provides users with the security of a virtual private network, Bohrer adds. MyID authenticates users through the use of an existing credit card and then allows them to connect to their desktop at a remote location.

eKiosk users can connect to the Internet for free at Provena for the first 10 minutes. After that, users pay a fee for minutes on-line, such as 10 minutes for $2.50. "Users can buy [additional] minutes like a pre-paid telephone card," says **Jack Querio**, eKiosk's senior vice president of sales.

The workstations also offer other services for nominal fees. These services include Microsoft Office applications, video e-mail, text e-mail, and text-to-any-fax number. Each unit has an audio headset jack and speaker, a video camera, microphone, IBM Microdrive reader, and floppy disc drive. The workstations also have an attached telephone handset with which users can call eKiosk's customer service department at any time.

The web's vantage

The workstations offer free, unlimited access to the information on Provena's eb site. "One of the greatest things from our vantage point is having our own web site displayed on the main screen when the eKiosk is not in use. This gives constant, high visibility to the medical center and its web site," Lagger says.

Hospitals such as Provena determine what information will be available on the workstations, Querio says. Users, for example, can click on the hospital's web site at any time to get information about employment and support groups, and to receive patient information on topics such as how to care for a new baby, Bohrer says.

Hospitals also can offer "way-finding" software on the workstations, which can help users maneuver around health care facilities, Bohrer says. "The hospitals have to provide the software, but the units are set to accommodate it."

eKiosks is talking with health care facilities about placing insurance information on the site, Querio says. "Patients could use the site to see if the hospital accepts their insurance and what kind of benefits they have."

eKiosks offers the first 10 minutes of Internet usage free because it finds various companies that want to advertise to the health care industry, Querio says. Diaper companies Huggies or Pampers, for example, might want to appeal to new parents. ■