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INSIDE

SEPTEMBER 2001

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A new standard form in Oregon creates a new standard in financial assistance

Access managers say it's unprecedented

In what appears to be an unprecedented effort, hospitals throughout Oregon have agreed to use a standard form for patients to apply for financial assistance.

As part of the collaborative effort, the hospitals have said they will post prominent signs and offer pamphlets and bilingual business cards telling patients how to apply for the monetary help, explains **Barbara Wegner**, CHAM, regional director of access services for Providence Health System in Portland.

Prompted by a consumer group, the initiative began with four hospitals in the Salem area and then moved to Portland, Wegner says. "It's nationally unprecedented," she adds, "that competing hospitals would get together and do something this substantive for patients who don't have coverage."

Although Providence and other nonprofit health care organizations already had procedures for applying for financial help, the agreement makes the process simpler for patients and for access personnel, Wegner points out. **(See a copy of the Providence application, inserted in this issue.)** "If a patient had been seen recently at another facility and had filled out a form, that person could present the form to a registrar and help facilitate the whole process."

In line with the guidelines, she says, Providence makes business cards available in waiting areas to inform patients of the financial assistance program in four different languages — English, Vietnamese, Spanish, and Russian. Applications also can be translated into other languages as needed, Wegner notes.

The project had its impetus about two years ago, when an advocacy group called the Oregon Health Action Campaign (OHAC) did a study to identify barriers to health care, says **Tim Miller**, MA, program manager and organizer for the Salem-based group.

"One of the problems we discovered was that people accessing health

care didn't know anything about charity care or free care," Miller notes.

Although nonprofit hospitals are not explicitly required to give charity care per se in exchange for their exemption from income and property taxes, he explains, they must by law provide "community benefits." Those benefits can take various forms, such as supporting a women's clinic, for example, or providing free care to those unable to pay, Miller adds.

'Nothing was uniform'

In the course of the study, he says, OHAC documented several cases of patients who would have been eligible for charity care according to the guidelines of the hospitals who treated them, but never learned about that option. Instead, they accumulated huge debts, were threatened by collections agencies and, in one case, declared bankruptcy, Miller says.

"The law is there, but the hospitals had different ways of [fulfilling] it and different standards," he adds. "Nothing was uniform. The community didn't know about it, and wouldn't know unless they found out by accident."

After hearing about the study findings, Miller says, the Salem hospitals, and later the Portland hospitals, agreed to work on a uniform charity policy. Eventually, the Oregon Association of Hospitals and Health Systems (OAHHS) adopted a voluntary agreement that set the standard for all Oregon hospitals in regard to free care, he says. **(See the OAHHS mission statement for the guidelines, p. 99.)** The OAHHS board approved a booklet developed by the Portland hospitals, *Financial Assistance Guidelines: A Suggested Policy for Oregon Hospitals*, for distribution statewide.

When the issue came before the OAHHS board about a year ago, the hospital association saw it as an opportunity to suggest common language that could be used in hospitals across the state, says **Karen Normandin**, communication director for the Lake Oswego-based association. "It took several months to hash over definitions and come up with a set of guidelines and to make the information available in several languages."

There's also a piece that has to do with employee education, Normandin notes. Employees in admitting, emergency department, and clinic areas are to be prepared to provide information on the program, she adds. "When eligible consumers are in the organization, they can ask questions about financial help, and [these employees] can direct them."

Plans are, Normandin says, for participating hospitals to get back together in a year and see how the program is doing. "One of the purposes is to network and collaborate so that everyone benefits."

From Miller's point of view, "the bad part [of the program] is that it's only voluntary. The good part is, it's the first agreement on a statewide basis in the nation." His organization's next step, he says, is to determine what can be done to make sure all hospitals participate.

However, Normandin says the financial assistance guidelines "would be pretty complicated to mandate. We have about 65 member hospitals, and about 40 of those are small, not as stable [as the larger participants]. It's a different situation in a lot of communities. We're participating in it as a voluntary program."

Oregon residents who make less than 150% of the federal poverty level — about $27,000 for a family of four — are eligible for the Oregon Health Plan, the state's health insurance plan for the poor. But they may be excluded for other reasons — for example, if they have more than $2,000 in cash or bank accounts.

The voluntary guidelines adopted by the Oregon hospitals state that financial assistance generally is secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability, and assets. They also state, however, that full financial assistance usually will be provided to a responsible party with gross family income at or below 150% of the Federal Poverty Guidelines.

Under the newly adopted policy, uninsured patients with incomes between 150% and 200% of the poverty level are eligible for aid on a sliding

COMING IN FUTURE MONTHS

- Why the differences in Medicare fiscal intermediaries
- Dealing with international patients and payments
- How to implement a CRM center
- More coverage for care of illegal aliens?
- What's the benchmark for patient identification?

Here's how the Oregon program is set to work

The Oregon Association of Hospitals and Health Systems put together this mission statement regarding the collaborative effort by the state's hospitals to make it easier to apply for health care financial assistance:

1. The objective of hospital financial assistance and services is to help the hospital meet its community obligations to provide financial assistance in a fair, consistent, and objective manner. The guidelines will provide structure to a discussion about a patient's financial need.

2. Hospitals will determine the best way to educate employees about the facility's protocols regarding assistance so that employees will know how to refer a patient or family to the appropriate location for information.

3. Request for financial assistance may be made at any point before, during, or after the provision of care. A responsible party choosing not to apply for financial assistance will not automatically be considered for assistance.

4. The guidelines include:

- Suggested policy statement regarding financial assistance.
- Sample screening practice for financial assistance.
- Sample operating policy.
- Sample account follow-up and collection practice.
- Sample wall sign and business cards.
- Suggested payment option explanation for reverse side of hospital statement. ■

scale to help pay hospital bills. The details of that scale are left up to each hospital, says Normandin.

The financial assistance given is specific to each admission, and the patient will be screened for changes in eligibility when there is a readmission or new episode of care, Miller says.

However, Normandin indicates, that screening process is greatly streamlined by the standardized application form. "My understanding is that the patient would have a copy of what was filled out [for earlier hospital visits], and that the information would be transferrable.

"There is a shared responsibility on the part of the patient and the person helping the patient fill it out," Normandin adds. "There is a requirement in the guidelines that the form be filled out completely."

The effort has generated "lots of positive comments," she says. "Folks are enthusiastic about using common language and not having to reinvent the wheel." And, she points out, "[providing assistance] is part and parcel of their mission." ■

Liaisons enhance the ties between docs and hospital

Goals: Increase revenue, bill correctly

Four physician liaisons at Straub Clinics and Hospital in Honolulu streamline the relationship between business services and caregivers, providing education on coding and feedback on billing errors, among other duties.

"If there is information about coding, changes in Medicare regulations, or any process at Straub that has an impact on physicians and their practice, these four people are the link," adds **Linda Dullin**, RN, director of admitting, whose department reports to business services. The physician liaisons also work under the administrator of business services and report directly to **Sheri Richard**, billing and operations manager.

"Their main goal, their whole function is to enhance revenue in the physician office and to ensure that [physicians] are coding and billing appropriately, to be the link with business services," Richard says. "They're able to give [physicians] feedback on what charges are being submitted and to make sure that a charge tag has been submitted on all patients."

Following trends

The physician liaisons work hand in hand with Straub's coding department, she says, learning about trends found from audits or from reviewing or spot-checking charges and then passing that feedback along to physicians.

If Straub's 150 or so physicians — in the hospital or in satellite clinics on Oahu and on the other Hawaiian islands — have questions about billing, "they have someone to go to," Richard adds.

The physician liaison positions were created, she explains, when Straub converted in July 1998

to the IDX computer system for both billing and admitting for hospital and clinics. At that time, the registration personnel in the physician offices began reporting to business services rather than to clinical operations, Richard says.

"The whole idea was that registration [errors] could be so detrimental to billing," she adds, that it made sense to have business services provide that oversight. To facilitate the relationship with these employees who were physically separate, the physician liaison positions were established.

Since that time, the physician receptionists have moved back under clinical operations, Richard notes, which makes the role of the physician liaisons more crucial than ever. The decision to return the employees to clinical oversight, she says, was the realization that they played a number of roles unrelated to registration. "The clinical operation [administration] truly believed they needed more control over the front desk [staff]."

Initially, the physician liaisons reported directly to her boss, the administrator of business services, Richard says, but since October 2000, she has been their supervisor. Because she supervises both claims processing and a department called Charge Corrections, where denials are handled, Richard can provide the data and information the liaisons need to do their job, she notes.

Brown bag it

The liaison positions are "really a good thing," Richard says. "[Otherwise], it's hard for the business office to get information to the physicians. They see a lot of errors, but there's no one to do the training and education." A problem with the billing for immunizations, she notes, led to the institution of brown-bag lunches to address billing concerns with physicians and their staffs.

"All the [immunization bills] needed an administration code and there were various types of codes and different bills for different payers," Richard explains. "[The physician offices] weren't picking the right code, and we were getting a lot of denials." A lunch session was scheduled to present the errors and discuss how to code the bills correctly, she adds.

The brown-bag sessions — at 11 a.m., noon, and 1 p.m. — now are held monthly and last about one-half hour, Richard says. "We usually take our top rejection or denial problem and pinpoint that issue."

The sessions, which are open to the entire organization, begin with a brief presentation and the distribution of cheat sheets on the topic at hand, she adds. "We're pretty focused." Afterward, the physician liaisons — who divide their duties by medical specialty, such as pediatrics or orthopedics — may meet separately with a group they cover, Richard says.

"We have data to show this is how much [the billing system] is kicking out for internal medicine or pediatrics and so forth and to show specific errors," she adds.

Richard, who chairs the brown-bag sessions, says she works closely with Straub's compliance department in planning the meetings. In most cases, the presentations can count toward the two hours of compliance education required annually for all Straub employees, including physicians, she notes.

"Physicians usually look at, 'What's in it for me?'" Dullin points out. "We look at whether [the topic] is something we can give them credit for. We have sign-in sheets that are turned over to human resources. That's something you can use as a hook."

An upcoming topic that she will address at the session, Dullin notes, is the handling of outpatient observation patients. "I will meet with the physician liaisons beforehand to go over the presentation and also to make sure that they provide feedback to me when questions arise from their physicians."

The presentation will probably be a group effort, she says, with involvement from other utilization/case management, medical records, and business services personnel.

An earlier presentation on advance beneficiary notices was made by Straub's former training coordinator and business services compliance advisor, Dullin adds.

Working with everyone

The physician liaisons, Richard points out, work individually with all the players in the physician practice. "There is the physician, the nurse, the clinical director, and the front desk supervisor, and we treat them each separately," she says. "Just because [the physician liaison] has talked with the physician, doesn't mean [he or she] has communicated with the whole department.

"Any employee of the organization can go to the physician liaison to ask about coding or reimbursement, and the liaison gets the answer and responds back," Richard adds. One of the

liaison's main goals, she notes, is to present to the physician various reports done by Straub. "There are financial reports and an accounts-receivable analysis. These tell the physician how well he's done, how many procedures he's done within that month."

The liaisons are responsible for providing education — on coding and other issues — to any new physician that joins the organization, she says.

'Minipreadmits' done by physician staff

Because physicians' offices and the hospital are on the same computer system, the physicians' staffs are able to do "minipreadmits" or "minipreregs" that facilitate the registration process, Dullin points out.

"If a patient goes to the physician and needs to get an arthroscopy, for example, someone in the physician's office goes into our computer system and does a mini prereg," she says. "Once they've done that, they also schedule the physician's time. They send a notice to us to anticipate that patient on this day for this procedure."

This eliminates the need for paper being faxed back and forth to arrange the procedure, Dullin adds.

Corrective action

Having a physician champion is another important way that patient access and business services can enhance physician cooperation and avoid having physicians feel "they're being dictated to," she says. "If the physicians are moaning about a certain thing, or just don't get it, you need somebody who will support what's being done and will be a link in communicating corrective action."

The medical director of a group that deals with a large number of patients from Pacific Ocean islands, for example, is a good person to champion issues that have to do with length of stay and utilization management, she says. Because those patients often require extensive care and follow-up, Dullin notes, that physician is particularly well-equipped to explain accompanying concerns to his colleagues. ■

Patients don't get orders as process is smoothed

Illegible, lost scrips not an issue

Southern Ohio Medical Center in Portsmouth has streamlined the process where a physician's order becomes a scheduled appointment for the patient, and improved its customer satisfaction in the bargain.

Rather than giving the order for an outpatient test or procedure to each patient as he or she leaves the office, the physicians' staff are asked to hold those orders until the end of the day, explains **Pamela Partlow**, RN, manager of registration and central scheduling.

Clarify information

The physician's staff make sure all the patient's demographic information is there and that there is medical necessity. It then batches all of the day's orders to the hospital by fax or courier, Partlow adds.

"We ask them not to give the order to the patient because the patient [often] loses it or can't read what the test is," Partlow says.

When that happens, her staff have to call the physician to clarify the information. By that time, the physician might not remember who the patient is, she adds. Patients who show up without the order, meanwhile, must wait until registration employees contact the physician's office and have another order faxed over, Partlow points out.

Green card

With the new process (which the 350-bed hospital began piloting in January 2001), patients are given a bright-green card with the telephone number for central scheduling, she says. The card instructs the patient to call the number within two to three days, Partlow adds. If the patient doesn't call to arrange an appointment within a week, registration staff make three attempts to contact the patient, she says.

"If [the patient] refuses to have the test or doesn't return the calls, we document all that on the order," Partlow explains, "and send it back to the physician's office for their files."

(Continued on page 104)

OUTPATIENT PHYSICIAN ORDER FORM (To reorder forms call 353-1660) # 133

CENTRAL SCHEDULING
1-740-356-8128
1-800-638-3978
1-740-356-5000
FAX: 740-353-1363

[ ] **MERCY CAMPUS**
1248 Kinneys Lane
Portsmouth, Ohio 45662
Registration Dept.
FAX: 740-354-1958

[ ] **SCIOTO CAMPUS**
1805-27th Street
Portsmouth, Ohio 45662
Registration Dept.
FAX: 740-353-5842

Date_____Arrival Time_____Weight_____Expected Date of Surgery_____

PATIENT_____DOB:_____ SS#:_____Phone:_____

Allergy Yes[ ] No [ ] (If yes, please specify allergy_____) Diabetic Yes [ ] No [ ]

PHYSICIAN=S SIGNATURE_____ DATE_____

PLEASE LIST ALL PATIENT=S DIAGNOSES:

[ ] Anemia
[ ] Atrial Fib
[ ] Congestive Heart Failure-CHF
[ ] Coronary Artery Disease-CAD
[ ] Diabetic
[ ] Hyperlipidemaa
[ ] Hypertension (HTN)
[ ] Hyperthyroidis
[ ] Prostatitis
[ ] Urinary Tract Infection-UTI

Other Diagnosis:
[ ]_____
[ ]_____
[ ]_____
[ ]_____

LABORATORY:

SMH Lab - **356-8280**
Ref Lab - **356-8700**

[ ] BASIC METABOLIC PANEL
[ ] BUN
[ ] Calciu
[ ] Chloride
[ ] CO2
[ ] Creatinine
[ ] Glucose
[ ] Potassiu
[ ] Sodiu

[ ] ELECTROLYTE PANEL
[ ] Chloride
[ ] CO2
[ ] Potassiu
[ ] Sodiu

[ ] COMP METABOLIC PANEL
[ ] Albumin
[ ] Alkaline Phosphatase
[ ] AST/SGOT
[ ] ALT/SGPT
[ ] Bilirubin Total
[ ] BUN
[ ] Calciu
[ ] Chloride
[ ] CO2
[ ] Creatinine
[ ] Glucose
[ ] Potassiu
[ ] Protein Total
[ ] Sodiu

[ ] OBSTETRIC PANEL
[ ] Antibody Rubella
[ ] Antibody Screen (Coombs Indirect)
[ ] Blood Typing ABO
[ ] Blood Typing Rh (D)
[ ] CBC w/Diff
[ ] Hepatitis B Surface Antigen (HBsAg)
[ ] RPR

[ ] HEPATIC FUNCTION PANEL
[ ] Albumin
[ ] Alkaline Phosphatase
[ ] Bilirubin; Total
[ ] Bilirubin; Direct
[ ] (ALT) (SGPT)
[ ] (AST) (SGOT)
[ ] Protein, Total

[ ] ACUTE HEPATITIS PANEL
[ ] Hepatitis A Antibod (HAAb), IgM Antibod
[ ] Hepatitis B Core Antibod (HbcAb), IgM Antibod
[ ] Hepatitis B Surface Antigen (HbsAg)
[ ] Hepatitis C Antibod

Additional Hepatitis Tests
[ ] Hepatitis B Surface Antibody (HbsAb)
[ ] Hepatitis B Core Antibod Ig
[ ] Hepatitis A Antibody Ig

[ ] LIPID PANEL
[ ] Cholesterol - Total
[ ] HDL Cholesterol
[ ] Triglyceride

[ ] LDL - Direct

[ ] RENAL FUNCTION PANEL
[ ] Albumin
[ ] Calciu
[ ] CO2
[ ] Chloride
[ ] Creatinine
[ ] Glucose
[ ] Phosphorus
[ ] Potassiu
[ ] Sodium
[ ] Urea Nitrogen (BUN)

[ ] ARTHRITIS PANEL
[ ] AN
[ ] RA Factor Qualitative
[ ] Sedimentation Rate/ESR
[ ] Uric Acid

CHEMISTRY
[ ] ART. Blood Gas
[ ] B12/Folate (Fasting)
[ ] CA-125
[ ] CE
[ ] Digoxin (6-8 hrs after dose)
[ ] Dilantin-Phenytoin
[ ] Serum Estradiol
[ ] Ferritin
[ ] Free T4
[ ] Glucola 1 Hr.
[ ] Glu 2 Hr, post pran.
[ ] Glu Tolerance_____Hr.
[ ] Hemoglobin A1C
[ ] Iron
[ ] TIBC
[ ] Magnesiu
[ ] Phosphorus
[ ] PSA Diagnostic
[ ] PSA Screening
[ ] Serum Protein Elect.
[ ] Tegretol-Crba
[ ] Theophyline
[ ]TSH
[ ] Valproic Acid

CARDIAC
[ ] CK-Diagnostic
[ ] EK
[ ] Troponin I

HEMATOLOGY
[ ] Bleeding Time
[ ] CBC w/ Diff
[ ] CBC w/o Diff
[ ] Protime/INR
[ ] PTT
[ ] Retic Count

URINALYSIS
[ ] Urinalysis w/Microscopic
[ ] Urinalysis Routine

XRAY:

Scioto - 356-8117

SEROLOGY/BLOOD BANK
[ ] Alpha-Fetoprotein/Maternal
[ ] Alpha-Fetoprotein/Tumor
[ ] HIV
[ ] Mono Test (Heterophile)
[ ] PKU
[ ] Preg Test, Quant.
[ ] Preg Test, Qual.
[ ] RA-Rheumatoid
[ ] RPR Qual.
[ ] Type & Cross Match____Units
[ ] Type & Screen

MICROBIOLOGY
[ ] Acid Fast Culture (Site)_____
[ ] Chlamydia (Site)_____
[ ] Fungus Culture (Site)_____
[ ] GC Culture (Site)_____
[ ] Genital Culture (Site)_____
[ ] H. Pylori antibod
[ ] Occult Blood (Stool)
[ ] Ova + Parasites (Stool)
[ ] Sputum Culture
[ ] Stool Culture
[ ] Strep Screen (Site)_____
[ ] Urine Culture (Cath/Void)
[ ] Wound Culture (Site)_____
[ ] Yersinia Culture (Stool)

OTHER:_____

_____

_____

_____

[ ] SURGICAL TEACHING

_____

[ ] ANGIOGRAPHY

_____

SAME DAY SURGERY
[ ] CM
Other:_____

U:\TECHS\SBC\PERSONAL\OPPB004.WPD-05/21/01

Table Weight Limit 350#

ABDOMEN
[ ] Acute Abdomen

[ ] Decubitus Chest
[ ] Plat & Upright Abd.
[ ] KUB

CHEST
[ ] Chest PA & LAT
[ ] Decubitus Chest R L
[ ] Ribs R L

EXTREMITIES - UPPER
[ ] AC Joints R L
[ ] Clavicle R L
[ ] Elbo R L
[ ] Forear R L
[ ] Hand R L
[ ] Humerus R L
[ ] Shoulder R L
[ ] Wrist R L

EXTREMITIES - LOWER
[ ] Ankle R L
[ ] Femur/Thigh R L
[ ] Foot R L
[ ] Hip includes pelvis R L
[ ] Knee R L
[ ] Patella R L
[ ] Tibia/Leg R L

SKULL AND FACE
[ ] Facial Bones R L
[ ] Mandible R L
[ ] Nasal Bones R L
[ ] Orbits R L
[ ] Sinuses R L
[ ] Skull R L
[ ] TMJ Joints R L

SPINE AND PELVIS
[ ] Cervical Spine
[ ] Lumbar Sacral Spine
[ ] Pelvis
[ ] Sacrum/Coccyx
[ ] Soft Tissue Neck
[ ] Thoracic Spine

FLUOROSCOPY
Call for Appointment 356-8128
[ ] Barium Enema (2)
[ ] BE with Air (3)
[ ] Esophagus/Ba Swallo
[ ] Gall Bladder (1)
[ ] Small Bowel (4)
[ ] Upper GI (4)

VENOGRA
[ ] Lower Extremity R L

GENITOURINARY
Call for Appointment 356-8128
[ ] Intravenous Pyelogram (5)
[ ] Nephrostomogram (5)
[ ] Voiding Cystogram

OTHER_____

CT SCANS
Call for Appointment 356-8128
Weight Limit 450#
[ ] Abdomen Onl
[ ] Abdomen/Pelvis
[ ] Chest/Thorax
[ ] Facial Bones

CT Scan (Contnd)
[ ] Pelvis Onl
[ ] Head
[ ] IAC=s
[ ] Neck Soft Tissue
[ ] Orbits
[ ] Sella/Pituitar
[ ] Sinuses
[ ] Spine
[ ] Cervical
[ ] Dorsal/Thoracic
[ ] Lumbar
[ ] Other: _____

ULTRASOUND
Call for Appointment 356-8128
[ ] Abdomen (7)
[ ] Abdomen Aorta (7)
[ ] Appendix
[ ] Biliary Tree/GB/Liver (11)
[ ] Breast
[ ] Chest
[ ] GB Only (13)
[ ] Liver (14)
[ ] Pancreas (12)
[ ] Pelvis (9)
[ ] Pelvis OB (8)
[ ] Pleural Effusion
[ ] Popliteal Space
[ ] Renal (10)
[ ] Retroperitoneal (13)
[ ] Soft Tissue Mass
[ ] Spleen (20)
[ ] Testicle
[ ] Thyroid
[ ] Urinary Bladder (9)

NUCLEAR MEDICINE
Call for Appointment 356-8128
Weight Limit 350#
[ ] Bone (17)
[ ] Cystography
[ ] Gastric Emptying Solid Phase (20)
[ ] Hepatobiliary (16)
[ ] Liver/Spleen
[ ] Lung Perfusion Ventilation Scan (V/Q)
[ ] Meckels Diverticulum (20)
[ ] Muga Heart or Gated Blood Pool
[ ] PYP Myocardiu
[ ] Renal mag3/dtpa Venogra
[ ] Thyroid Scan 123I Uptake & Scan (18)
[ ] Thyroid Scan Technetiu 99 mTc

NUCLEAR MEDICINE-SPECIAL STUDIES
[ ] ACE Inhibited Renal Scan (30)
[ ] Bone Scan for Osteomyelitis (3 phases)
Stress Pets of Extremities
[ ] First Pass Muga
[ ] Gallium (21)
[ ] Hepatobiliary with Gall Bladder Ejection Fraction (16)
[ ] WBC Spid

OUTPATIENT REHAB SERVICES:
Call for appointment:
UPK Center Rehab 356-7632
Wheelersburg Rehab 574-8189

Specialty Programs
[ ] Spine Progra
[ ] Fibromyalgia Prngm
[ ] Osteoporosis Progra
[ ] Pre/Post-natal Rehab

Physical Therapy
[ ] Evaluate and treat
[ ] Other: .

Occupational Therapy
[ ] Evaluate and treat
[ ] Other:_____

Industrial (BWC) Rehab
[ ] Evaluate and treat
[ ] Other:_____

Neurologic Rehab
[ ] Evaluate and treat
[ ] Other:_____

Speech - Language Pathology
[ ] Evaluate and treat
[ ] Other: _____

Audiology
[ ] ABR Auditory Brainstc Response
[ ] ENG Electronystagmograph
[ ] Hearing Evaluation

[ ] Cardiac Rehab
356-7663
[ ] Pulmonary Rehab
356-7397

CARDIO-VASCULAR LAB
Call for Appointment 356-8128
Report to Registration
[ ] Adenosine Cardiolyte (23)
[ ] Arterial Imaging U L
[ ] Arterial/Non-Invasive with or without exercise U L
[ ] Carotid/Non-Invasive
[ ] Cardiolyte Stress (20) Weight limit 300#
[ ] Dobutamine Stress Echo Test
[ ] Echo
[ ] Echo/Doppler
[ ] Event Recorder
[ ] Holter Monitor (22)
[ ] Stress Echo Test
[ ] Stress Test (15)
[ ] Transesophageal Ech U L
[ ] Other:_____

RESPIRATORY
[ ] Medication Aerosol/Nebulizer
[ ] Sputum Collection (27)
[ ] Other:_____

PULMONARY DIAGNOSTIC
Call for Appointment 356-8128
[ ] Bronchial Provocation
[ ] Desaturation/Stud
[ ] Metabolic Stud
[ ] MIP5/MEP5

Pulmonary Diagnostic (Contnd)
[ ] Pulmonary Function, Challenge
[ ] Pulmonary Function Complete
[ ] Pulmonary Function, Screen
[ ] Pulmonary Function, Stress Call 356-8485
[ ] Pulmonary Function, Stress 3 LD
[ ] Pulmonary Function Stress 12 LD

SLEEP LAB
Call for Appointment 356-8128
[ ] Sleep Lab (29)
[ ] Other:_____

DIABETIC TEACHING
Call for Appointment 356-8128
[ ] Diabetic Education Series
[ ] Gestational Diabetes Counseling
[ ] Home Glucose Monitoring Instructions
[ ] Insulin Administration Instructions
[ ] Nutritional Counseling

EEG
[ ] EEG (24)
[ ] Sleep Deprived EE
[ ] Other:_____

MAMMO/WOMEN'S CENTER
Call for Appointment:
356-8128 - 1-800-638-3978
Report to the Breast Center for Registration
[ ] Screening
[ ] Diagnostic (To include Mag View and/or U.S. as needed) (28)
[ ] Indicated Study Due to (specific mass site); _____
[ ] Medical History of (specify)
_____

DEXA SCAN Weight Limit 300#
_____

_____

M.R.I.
Weight Limit 450#
Call for Appointment 356-8128
Report to MRI for Registration
[ ] MRI Study Desired_____
[ ] Clinical findings supporting
[ ] Other relevant history or comments:_____
_____

MATERNITY OUTPATIENT ANTEPARTUM TESTING
[ ] Amniocentesis
[ ] Cesarean Section Pre-O Education
[ ] Non Stress Test
[ ] O.C.T - Stress Test
[ ] Rhogam-Antepartu
[ ] VBAC - Education

Source: Southern Ohio Medical Center, Portsmouth.

(Continued from page 101)

To facilitate the process, the hospital hired seven employees and now offers central scheduling services between 7 a.m. and 11 p.m., she says. The impetus for that substantial investment was customer service, Partlow adds. "Patients [had been] very dissatisfied with coming in and having to wait an hour to get registered for an outpatient procedure. Then they would have to go to the department [where the procedure was to be performed] and wait about another hour. That's been cut down greatly, too."

To make the handling of orders more efficient, she notes, the hospital provides free outpatient order forms to physicians. **(See form, pp. 102-103.)**

"That way, when they batch [the orders], they are all the same. Many physicians just use [prescription pads] to write the orders, but our forms include all the tests; they can just make a check mark by the appropriate one."

Patient satisfaction

The reason all this has been worthwhile, Partlow says, is that patient satisfaction has dramatically increased. "Now the patient just walks up and is already preregistered. They don't have to wait, and we don't have to make numerous calls because someone forgot the order."

In addition, she says, the outpatient departments know that at a particular time, a certain number of patients are scheduled to have a certain procedure, so departments can staff accordingly. Before, patients could just walk in without an appointment and present an order for a basic lab test or X-ray. The departments didn't know how many patients to expect, Partlow notes. Even procedures such as CAT scans and cardiac tests were done on a walk-in basis, she adds.

Since the pilot program began in January, the hospital's policy is that all outpatient tests — including complete blood counts — are scheduled by the patient through central scheduling, Partlow says. The results have been gratifying, she adds, with most waits reduced to two or three minutes.

Reduce lost orders

In addition to increasing patient satisfaction and reducing the number of lost orders and phone calls to the physician offices, the new process offers physician staffs a check-and-balance system, she points out.

"When we schedule an appointment, we fax [the physician office] a confirmation form so they can see if they ordered the right test," Partlow says. "Also, that confirmation has the date and the time of the test so they know when they should be getting the results." This fax-back confirmation feature is an optional part of the process, she notes.

Of the 100-plus physician practices in the area, Partlow says, about 30 participate in the new process.

'If you feed them, they will come' — and eat

To promote cooperation and compliance from the physician practices, Southern Ohio Medical Center hosts a quarterly "registration and central scheduling informational breakfast meeting," she notes. Although the breakfast meeting was established before she joined the department four years ago, Partlow says, attendance has increased dramatically since she began promoting it. The breakfast now draws between 90 and 100 attendees, she notes.

Her theory, Partlow says with a laugh, is, "If you feed them, they will come."

The staffs of all physician offices and nursing homes in the area are invited, she says, and the audience may include nurses, office assistants, unit clerks, and nursing home administrators. Also attending in addition to herself are the supervisors for registration and central scheduling.

"We may have other department directors or supervisors," Partlow adds. "For example, the director of the cardiac lab [did a presentation on] how to prep patients before a cardiac test, and the correct way to explain things to the patient."

As part of another program, she says, a physician discussed mammograms and breast cancer, and the supervisor of the breast center explained the difference between a screening mammogram and a diagnostic mammogram. That distinction, Partlow notes, is a medical necessity issue and should be addressed during the registration process.

"Medical necessity has been a big [topic] lately," she adds. "We've gone over with [physician staff] the need to have a diagnosis on the test ordered. If they have a question, they ask at the meeting, or they call later. It's a share of information back and forth." ■

Look for nonverbal cues to prevent violent episode

ID levels of behavior, expert says

The key to defusing a potentially violent situation in, say, a hospital emergency department (ED), lies in identifying the levels of behavior the disruptive individual is going through, advises **Judith Schubert**, executive director of the Crisis Prevention Institute (CPI) in Brookfield, WI.

Tuning in

Access personnel are familiar with the typical waiting room, Schubert points out, where being behind schedule and impatient behavior are the norm. What registrars should be attuned to in such a situation, she suggests, are verbal and nonverbal cues that the anxiety is escalating.

"The signs may be that someone who's sitting and reading a magazine starts to just flip pages, and to stand up and sit down," Schubert says. Often, the way to prevent a more disruptive scene is simply to acknowledge the person's wait by offering them something or just paying attention to their plight, she adds.

"Would you like a glass of water?" or "There are more magazines over here," Schubert notes, are comments that can calm the person. "In their own mind, they're there by themselves, but you can let them know that you're there with them. You're not always able to take away the aspect that's making them anxious — the long wait — but you can be supportive."

This response to early warning signs, she says, is one of the most effective strategies for health care personnel.

Although health care organizations have always been part of CPI's client list, Schubert notes, "we're seeing more and more health care professionals requesting training." That's due in part, she suggests, to guidelines addressing workplace violence issued in 1996 by the Occupational Safety and Health Administration. "Training is a key component of those guidelines."

When a gun's involved, here are tips to follow

Access professionals by definition are often the first line of defense when it comes to unruly or aggressive patients or family members in a health care setting.

Even in a worst-case scenario — one in which the patient or family member wields a weapon — there are actions the health care worker can take to try to defuse the situation, says **Judith Schubert**, executive director of the Brookfield, WI-based Crisis Prevention Institute (CPI).

Dramatic television scenes notwithstanding, the best course of action is to avoid attempting to disarm the person, Schubert emphasizes. "Our efforts should be on what to do to get the law enforcement individuals there."

Schubert offers these tips for access personnel who find themselves dealing with an armed individual.

1. Stay calm.

Do this in whatever way works for you, Schubert says. "Some people reflect on a plan, some do positive self-talk. If the individual threatening with the weapon senses we're losing control, the situation can escalate."

2. Avoid rushing the person.

3. Focus on the individual, not the weapon.

"Remember that a gun will present no danger until someone decides to fire it," Schubert says. "If you do this, you're more likely to communicate calm to that person."

4. Negotiate.

"Understand the power of negotiation to be as simple as getting some kind of 'yes,'" Schubert advises. That "yes," she says, can be to a question as simple as "Is it OK if I take a step back?" or "Can we sit down?" Those little "yesses" add up, Schubert adds. "In a negotiation, the more someone complies or has that rapport, the less likely the person is to shoot."

5. If there is a risk for weapons, policies and procedures should be clear to staff.

Everyone, not just security personnel, should know how to respond, she says.

[Editor's note: CPI can be contacted at 3315-K N. 124th St., Brookfield, WI 53005; Telephone: (800) 558-8976; e-mail: info@crisisprevention.com.] ■

But when her company is asked to do "a two-hour training course because the organization is concerned about physical aggression," it's more than likely to decline, Schubert says. Rather than a short course in "how to take someone down," she adds, CPI advocates a holistic program. "We do address issues of physical violence, but it's a comprehensive approach rather than a quick fix."

Quoting Abraham Maslow, one of the founders of humanistic psychology, Schubert cautions, "If the only tool you have is a hammer, everything around you starts to look like a nail." With that in mind, she says, the focus is on how to prevent a situation from turning violent in the first place. Different responses, Schubert adds, fit different levels of behavior.

Suppose that impatient person in the ED, for example, goes up to the desk, loudly demands to be seen, and when the registrar asks him to sit down, says, "Why don't you make me?" At that point, she says, the calming offer of a glass of water is no longer the best response.

The tough jobs

Instead, the registrar should become more direct with what she wants the person to do, Schubert adds, and offer a choice. The registrar might say something like, "If you can sit and stop yelling, you can continue to wait here, but if you're disruptive you will have to leave."

If the person doesn't comply and the registrar asks him or her to leave, or if he or she acts out physically — by throwing something, perhaps — it's important that the health care employee "wrap it up" with that individual, she says. The registrar, Schubert adds, might say on the person's next visit something like, "I want to talk to you about what happened on Thursday. I know you became anxious. What can we do so this doesn't happen again?"

Otherwise, she notes, the person might get frustrated again, or might wonder what the staff are thinking of him or her in view of the past behavior.

When there is physical aggression against an employee, it can be traumatic for the staff, Schubert points out. "They may have fears about not just that individual, but about the ED the next time it's crowded after a particular event, for example."

After such incidents happen, she says, it's important to "debrief," by talking to staff about what occurred, how it occurred, what the patterns were, and how to prepare for next time. Different people may have different perspectives on the incident and the discussion can help put together the pieces as to what actually happened, Schubert adds.

Thoughts of the most extreme situations — those involving a weapon or a person who is physically aggressive — often prompt people to consider taking a training course, she says. CPI, however, wants people "to come together and to organize their thinking about a lot of things they already know about," Schubert notes.

Those who are employed in a health care setting, she suggests, "already have a toolbox of things that work. We try to identify what those things are, and [determine] the best times to use those skills and strategies." ■

EMTALA violations are seen in nearly all states

More than 520 hospitals in 46 states, the District of Columbia, and Puerto Rico have violated the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by denying patients access to quality emergency health care, according to a report by the Washington, DC-based consumer group Public Citizen.

The report says 500 hospitals violated the screening, stabilizing treatment or transfer provisions of EMTALA between 1997 and 1999. Violations of EMTALA, which guarantees patients access to emergency care regardless of their ability to pay, have racked up more than $1 million in fines, the report says. A few of the violations in the report were confirmed in 1996 and 2000.

Administrative trouble

Not all the hospitals violating the act actually "dumped" patients, which refers to the inappropriate transfer of a person whose condition is not stable. Some violations were administrative in nature, involving such actions as omitting documentation or failing to post signs spelling out patients' rights.

The report lists the name of each hospital, the nature of the violation, and any fines assessed against the hospital. Of the 500 hospitals that had confirmed violations in 1997, 1998, and 1999 and were eligible to be fined, 85 (17%) had been fined as of April 2001.

States with no confirmed violations listed in the report are Delaware, Hawaii, New Mexico, and Wyoming. To find out which hospitals in a particular state violated the law, people can visit the web site www.citizen.org, go to "Questionable Hospitals," click on a map of the United States, and select the state. A copy of the report also is posted there.

Among the report's key findings are:

• Nationwide, for-profit hospitals had a significantly higher rate of violation (1.7 times higher) than not-for-profit hospitals.

• Up to one-third of surveyed emergency department registration staff recently told the U.S. Department of Health and Human Services that patients might be asked for insurance information before a screening is provided or while it is taking place. Thirty-five percent said they contact health plans for authorization of screening exams at some point. These actions violate the law if they delay treatment.

• Hospitals are being fined more than in previous years. Civil money penalties increased from $130,000 in fiscal 1988 to more than $1 million in each of 1998, 1999, and 2000. However, most hospitals with confirmed violations are not fined, the report says. ■

Report: Mergers may save less than thought

A report commissioned by the Agency for Healthcare Research and Quality suggests that hospital mergers may produce fewer savings than previously estimated.

The study, which appears in the July issue of *Health Affairs,* traces the cost and price changes in nearly 1,800 short-term hospitals from 1989 to 1997. Researchers, who compared merging hospitals in high HMO-penetration markets with their nonmerging rivals, said the merging hospitals' average cost savings was 2.3 percentage points.

The average price growth was nearly identical to nonmerging competitors, according to the report. Conversely, in low HMO-penetration markets, mergers appear to produce greater cost and price savings for the hospitals. The report, "Hospital Mergers and Savings for Consumers: Exploring New Evidence," can be found at www.healthaffairs.org. ▼

Ohio joins the states with prompt-pay laws

Ohio Governor Bob Taft has signed into law legislation aimed at ensuring that hospitals

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Editorial Questions

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and other health care providers receive timely payments for services.

Taft signed the bill in late July at Doctors Hospital West in Columbus. Senate Bill 4, the prompt-pay bill that passed the Ohio General Assembly in late June, becomes effective in one year.

Check your status

The Ohio Hospital Association reports that the new law requires insurers to establish a system whereby providers and patients can check the status of a claim. It also requires insurers to pay claims within 30 days, or 45 days if the insurer needs additional documentation. And, it prohibits insurers from contracting for time frames longer than those stipulated in the bill.

At the bill signing, the governor said the new law will allow hospitals and doctors to spend more time on medicine and less time collecting bills. ▼

Hospital closures are said higher this year

During the first half of this year, 24 hospitals with 4,088 staffed beds have either closed their doors — partially or entirely — or announced plans to do so, compared with 20 for the same six months last year, according to an Ohio health care consulting firm.

Dynamis Healthcare Advisors of Cleveland said the closure trends this year are similar to those exhibited in 2000. Five of the 2001 closures have been in rural communities, and 19 were urban hospitals. Seven of this year's closures were for-profit and 17 were not-for-profit facilities.

Midwestern closures

Geographically, most of this year's closures were in the Midwest, followed by the East Coast. Ohio led the list of closures with four closures or announcements. At the same time last year, Ohio also led the list with five. Closures to date in 2001, according to the report, have affected 4,203 staffed beds and approximately 13,000 employees. For more information, go to www.dynamis-hc.com. ▼

CMS to conduct listening tours

The Center for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) will conduct listening tours to get input on running those government programs more efficiently, says CMS administrator **Tom Scully**.

Making the announcement at a House of Representatives Small Business Committee hearing focusing on reducing the paperwork burden for small health care providers, Scully said the move marks the first of several steps geared toward reform, according to a report by the on-line news service *AHA News.*

Next, CMS will convene seven health-sector work groups to meet with advocacy groups in Washington representing all facets of the health care work force, Scully said. They will focus on improving interactions with CMS and reducing regulatory complexity and burden. ■

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PATIENT'S NAME LAST	FIRST	M.I.	SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH	U.S. CITIZEN ☐ YES ☐ NO	NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP

The following information should be about the person responsible for paying the bill.

ADDRESS STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME _____ WORK _____

DATE OF BIRTH	NO. OF PEOPLE IN HOUSEHOLD	AGES OF CHILDREN IN HOUSEHOLD

NAMES OF PEOPLE EMPLOYED, FULL-TIME OR PART-TIME, IN HOUSEHOLD / RELATIONSHIP
PERSON 1 _____
PERSON 2 _____
PERSON 3 _____

HEALTH INSURANCE COVERAGE (CHECK ALL THAT APPLY FOR YOUR HOUSEHOLD)

☐ MEDICARE; IDENTIFICATION NUMBER: _____

☐ MEDICAID; STATE IDENTIFICATION NUMBER: _____

☐ PRIVATE INSURANCE; NAME OF COMPANY: _____ GROUP NUMBER: _____ I.D. NO.: _____

☐ OTHER: _____ I.D. NO. _____

HOUSEHOLD INCOME Please provide the following information for each person, if applicable:

	PERSON 1	PERSON 2	PERSON 3
MONTHLY WAGES / SALARY (BEFORE TAX INCOME)	$	$	$
UNEMPLOYMENT	$	$	$
SOCIAL SECURITY, PENSIONS	$	$	$
ALIMONY / CHILD SUPPORT	$	$	$
OTHER (Stocks, Bonds, IRA's, etc.)	$	$	$

Please list any other unpaid hospital or doctor bills.

HOSPITAL / DOCTOR OWED	CURRENT BALANCE	MONTHLY PAYMENT

SUBTOTAL _____

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TRAN CODE _____ ☐ TRADITIONAL MEDICARE

☐ APPROVED ASSISTANCE _____ PERCENT(%) CORPORATE # _____ BALANCE _____

SEND NOTICE OF DETERMINATION: ☐ YES ☐ NO ACCOUNT # _____ BALANCE _____

ACCOUNT # _____ BALANCE _____

APPROVED BY: _____ ACCOUNT # _____ BALANCE _____

CONTINUE ON BACK SIDE OF SHEET

EXPENSES

Please list all household credit cards or other commercial accounts (e.g. VISA, Mastercard, American Express, department store accounts, student loans, etc.)

NAME OF CREDITOR	CURRENT BALANCE	MONTHLY PAYMENT
	SUBTOTAL	

Please list all other monthly household living expenses.

	MONTHLY PAYMENT		MONTHLY PAYMENT
MORTGAGE PAYMENT		GASOLINE OR OTHER TRANSPORTATION	
Tax Value		CHILD CARE	
Mortgage Balance			
RENT		INSURANCE (Home, Car, Health, Life)	
CAR PAYMENT(S)		TAXES	
Make(s) / Model(s)		MEDICATIONS	
Year(s)			
FOOD		OTHER:	
UTILITIES		OTHER:	

Does your household have checking account(s)? ❑ YES ❑ NO If Yes, Balance: _____

Does your household have savings account(s)? ❑ YES ❑ NO If Yes, Balance: _____

Have you ever filed bankruptcy? ❑ YES ❑ NO If Yes, When: _____

Please make additional comments about your household's financial circumstances that may affect your ability to pay the hospital bill:

Please check that you have provided: ❑ Previous year's tax returns ❑ Income verification showing year to date earnings or paystubs for the last 3 months.

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I understand that Providence may verify the above information.

X _____ _____

RESPONSIBLE PERSON'S SIGNATURE DATE

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