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INSIDE

JULY 2002

VOL. 21, NO. 7 (pages 73-84)

Proposed changes to EMTALA rule still lack clear direction, expert says

Prior authorization, off-site locations addressed

Proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations indicate an attempt to "clear up areas that get the loudest complaints," but still don't give providers the direction they need, says **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

"What people in the field really wanted is missing here," adds Frew, a web site publisher (www.medlaw.com) and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison. **(See related story, p. 75.)** In the proposed final rule, which would become effective in October after a comment period that ends July 8, the Centers for Medicare & Medicaid Services (CMS) "has tried to give examples and talk about the policies it expects to see, but still doesn't say what the policies are expected to contain, what they mean in practical terms."

While the proposed rule generally represents "some changes in what's in print, but not necessarily a lot in application," he says, there are some significant differences that should be of particular interest to access managers.

When it comes to issues regarding Medicare+Choice plans, Frew says, the proposed rule reiterates that the patient must be stabilized before any calls can be placed for prior authorization and points out that a patient may need admission and surgery before he or she can be stabilized.

"So you have to go to the point of stability — a medical determination — before the call is made," he adds. "That basically leaves a situation where calls for prior authorization are hazardous. In the emergency department [ED], [providers] just can't do it."

EMTALA regulations have been enforced that way for 15 years, Frew says, but some hospitals have continued to interpret the stabilization requirement more loosely. "Because they are trying to make things more efficient, they've said, 'We're not delaying care; we're doing [authorization calls] simultaneously,'" he explains.

That's a problem, he says, "because of the implications of what a denial from the payer might do midstream. [CMS] is maintaining its position on that and emphasizing that [providers] have to call Medicare Choice and Plus plans [for authorization], but just like with all the rest of the payers, they have to wait until the patient is stable."

What the proposed change in the prior authorization section boils down to, adds **Linda Fotheringill**, a partner in the Towson, MD, law firm Siegel & Fotheringill, is that before a call can be made to an insurance company to obtain authorization, the medical screening exam must be completed as well as "any further medical examination and treatment that may be required to stabilize the emergency medical condition.

"So the point is, when is that 'magic moment' [when stabilization occurs]," adds Fotheringill, whose firm specializes in health care issues and payer denials. "The proposed regulation is very unclear and subjective as to when a call could be made to the insurance company."

Fotheringill says she believes CMS recognizes that the provision is unclear, and that is why the agency is requesting additional comments as to whether it should be further revised. "They're asking whether the proposed regulation should be revised to state that the hospital may seek information from the insurance company and obtain authorization while providing stabilizing treatment — then they qualify that by saying 'apart from information about payment.'"

There is a discussion in the *Federal Register* about seeking comments on further changes that can be accessed by going to www.emtala.com, taking the direct link to the CMS comments on the proposed regulations, and looking at page 31,471, she points out.

"They're talking about adding language [allowing] the hospital to call and get authorization so long as there is no delay in screening and stabilization services, but at the same time, they are prohibiting the hospital from obtaining information for payment," Fotheringill says. "Why would the hospital want to make what would amount to a meaningless call?"

Another confusing change under the prior-authorization section of the rule, she suggests, is that the proposed section states that for hospitals to be paid for post-stabilization care, they must notify the Medicare+Choice plan "promptly" after stabilization, but does not define "promptly."

But at the same time, Fotheringill points out, the proposed rule change says the hospital's attempts to obtain preapproval are to be consistent with another section of the rules.

"If the proposal goes through as is, it's setting up a situation where there will be more denials because the Medicare+Choice plans will be the ones making determinations as to whether the call was prompt," she adds. "As written, it appears that if the payer is not contacted 'promptly,' there will be few ways to overturn the denial that will undoubtedly occur. The bottom line is, I would suggest, that this section is limiting the hospital further."

250-yard rule

Another proposed change that is significant has to do with EMTALA's 250-yard rule, Frew says. "Previously, [the law] was set up to say that if a patient made it within the 250-yard zone or to hospital outpatient departments, he was covered by EMTALA."

The proposed change, he adds, is to limit that provision to hospital departments and off-site locations that are regularly used for unscheduled patient visits. CMS is asking for comments, Frew points out, on how to distinguish between a location that gets an occasional walk-in patient and one that is dealing with such patients enough to be held to the rules.

It is important for access managers to weigh in on this issue, he suggests, noting that comments will be accepted through July 8, 2002. "[CMS] is asking for a definition of 'significant portion of the time.'"

The proposal regarding the 250-yard rule indicates that CMS officials "are pulling in [EMTALA boundaries], but are not pulling in as far as it had been anticipated they might," he notes. Some

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members of Congress, Frew says, including EMTALA sponsor Rep. Pete Stark (D-CA), had said CMS "had gotten carried away with remote stuff."

Still, Frew says, the proposal limits the number of locations where EMTALA would directly apply. "It does still indicate that [personnel at these off-site locations] would be expected to do the best they can and call 911, but it lets them out of calling the ED, arranging for transport to the home hospital, and those kinds of issues."

The proposed rule goes on to say that if a patient presents in an area other than the ED with, for instance, a gash in the head, the receptionist is to summon aid, not send the patient somewhere else to get help, Frew says. "It also talks about allowing nurses in other situations to make the determination that the patient's condition isn't urgent and to send them elsewhere."

For example, he adds, if a patient previously had sutures and was told by the physician to come back to have them taken out, the nurse can assess the wound and send the patient to an outpatient clinic to have them removed.

"If the patient starts the visit as an outpatient on a scheduled basis, [the law] will assume for the course of events that the patient is not covered by EMTALA," Frew says. However, he adds, the proposal does give several examples. "If in the course of a visit, the patient should experience the sudden onset of a new condition — like having chest pain while blood is being drawn — then it is expected at that point the hospital will initiate EMTALA-type care."

Asked if that would not be an obvious course of action in a health care setting, Frew points out that in most such cases, hospital personnel call the patient's physician, who directs them to send the patient over for an assessment.

Another 'touchy' subject

Another EMTALA provision that is "a real touchy point" with hospitals has to do with policies regarding on-call physicians, he says. In the new proposal, CMS "reiterates that there is no hard-and-fast rule, but reserves the right to disagree with everything the hospital does."

"It depends on a lot of variables," Frew explains. "They are putting in writing that the hospital is free to decide how many physicians are on call in each specialty, but they will look at that and determine the capability of the hospital. It gets back to what they've always done in the past, which is second-guess the hospital."

CMS may have intended this change to be reassuring, he notes. "They are saying that it is not automatically a problem to allow senior physicians to be exempt from call, unless it compromises care."

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Read between EMTALA lines for 'ominous' message

Challenge likely on inpatient stance

There is an "ominous" overtone and at least one glaring opportunity for court challenge in the proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations, suggests **Stephen Frew**, JD, a longtime health care attorney and EMTALA expert.

"What's ominous is that even though EMTALA may not apply [in certain situations], the Medicare Conditions of Participation do," says Frew, a web site publisher and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison.

In several instances in the proposed rule, he points out, the Center for Medicare & Medicaid Services (CMS) states that even if EMTALA doesn't apply, it has the right to look at a hospital's actions under the Conditions of Participation. Although the language may not seem significant to lay people or even health care providers, Frew notes, there is a between-the-lines meaning for those familiar with the law.

"This says to me, 'We may let you off under the strict wording of EMTALA, but don't think that gets you out of everything,'" he says. "This is the regulator's way of saying, 'We're warning you. Don't think you can push the limit. We still expect reasonable conduct. If you push it, we'll nail you.'"

The message, Frew adds, is that CMS is

"loosening the chokehold, but still keeping hold of the throat."

When the proposed rule addresses EMTALA's application to inpatients, he continues, it opens itself up to "substantial court challenge," using logic that is "entirely contrary" to a long history of court decisions on the law's application.

The rule says that if a patient moves in and out of a stable condition, EMTALA applies, Frew notes. But if a patient comes in for an elective procedure and becomes unstable while in the hospital — for example, has an embolism while having knee surgery — the patient would not be covered by EMTALA under the CMS interpretation, he adds.

The CMS interpretation is that the person in such a situation would be covered by the Conditions of Participation, he says. "The [hospital] still has to do what is medically necessary."

"A patient might have a problem and Dr. So-and-so says he would rather deal with the problem at another facility," Frew adds. "Under EMTALA, [the hospital] couldn't move the patient unless it had to."

By holding such situations to the lesser standard of the Conditions of Participation, he suggests, "CMS is ignoring a major court ruling that interprets this differently. It doesn't matter which door the patient comes in, [according to that ruling] if the hospital is where the patient has an unstable condition, he is covered by EMTALA."

CMS will be challenged on this point, Frew predicts, "because those situations have resulted in lawsuits before."

Continuing lack of clarity

The proposed new regulations are written in the same "bureaucratic language that can be misinterpreted," Frew notes, which is his major criticism of the rule.

"Providers read the section that says it's up to the hospital how many physicians are on call, but then CMS says we can second-guess you," he says. "They're in the dark until they're nailed."

The new regulations represent an effort to put in writing the agency's general philosophy, Frew adds, "but philosophy doesn't help people with compliance."

More than 97% of respondents to a survey Frew did on his web site, www.medlaw.com, said they agreed with EMTALA, he notes, but that they wanted "consistency, clarity, and a safe harbor" in regard to the law. "They said, 'Give us the line in the sand so we know where we stand and then tell us if we do this, we don't have to worry,'" Frew adds.

The government has created safe harbors — "a set of rules that says if you follow these, we're not going to second-guess you" — for Medicare fraud and abuse, Frew points out. "If they can create fraud and abuse safe harbors, which are much more complicated, they should be able to do the same for EMTALA."

The difference, Frew says, is that CMS doesn't know how hospitals operate. "They're not familiar with how different hospitals function, what patient flow is, what referral flow is, so when they put in rules that cause problems, they are pretty much bewildered." ■

Staff, training improvement part of access makeover

New uniforms are part of the package

The patient access department at Centegra Health System in McHenry, IL, has undergone what can best be described as a total makeover, with expanded staffing, a revamped training program, and a new focus on registration accuracy and regulatory compliance.

Registrars even have begun wearing uniforms as part of the departmental overhaul, says **Liz Kehrer**, CHAM, system administrator for patient access.

The changes began around April 2001, when Kehrer — formerly patient access manager — assumed her new position **(see related story, p. 78)** and **Deb Fanning** was hired to be the new access manager. After years in which she held all the responsibility for the daily departmental operations, staff training, quality assurance (QA), and regulatory compliance at the system's two hospitals, Kehrer explains, Centegra's administration made the decision to distribute the access workload.

Several factors got the attention of administration, she says, including turnover among registrars, new staff's frustration with inadequate training, and quality assurance problems. "We were spending so much time fixing [bills] later," Kehrer notes.

"There was a steering committee at the time

looking for opportunities for improvement," she adds. "We made recommendations to that committee and got the green light to move forward. We had a lot of support from the CEO."

Several new access positions were created to take over some of the hats formerly worn solely by Kehrer, she says. They include a patient access supervisor at each of the system's two hospital campuses, a departmental trainer, and the new system administrator position that she now holds.

'Super registrars' can't do it all

Previously, Kehrer adds, she relied on a lead registrar at each hospital to serve as a resource for staff when she wasn't available. Although these "super registrars" could answer staff questions, they weren't able to help with such supervisory functions as discipline or hiring and firing, she says. "They didn't have time for that. They were working registrars who had patients lined up at their desks, too."

The results have been dramatic, notes Fanning. Improvements include a drop in accounts receivable (AR) days, which have gone from 59 to 49, and an increase in customer satisfaction, as measured by the patient satisfaction surveys by Press, Ganey Associates of South Bend, IN.

Fanning says she gives much of the credit for improvement in AR days to the new QA process. "We selected two of our top people as far as quality of work and put one at each facility," she says. "They go through all the registrations for the day — today, they do yesterday's — and make sure everything is correct."

The QA specialists give feedback to registrars who have made mistakes, and if the problems are consistent, those people may be sent back for more training, Fanning adds. At present, she says, the QA staff are auditing 66% of the hospital's registrations, with plans to increase that to 100% within the next couple of months.

To facilitate that goal, Fanning says, two more QA specialists are being added to perform the same functions on the evening shift.

Although her position and those of the two supervisors and the first two QA employees represent an increase in staff, many of the other changes have been made through "creative staffing," she notes. For example, to form a new centralized pre-registration team, Fanning adds, she took four registrars from each hospital. **(See related story, p. 78.)**

The improvement in customer satisfaction, she suggests, is related to the attention that now is being given to the registrars, which in turn encourages them to take more care with patients. With supervisors in place at the two hospitals, "they now have someone they can go to" with questions and concerns, Fanning says. Those who meet monthly goals for collections and for the inpatient and outpatient Press, Ganey surveys receive a $25 gift certificate, she adds.

The health system has been recognized for its achievements with two certificates for best practices in access management from the consulting firm Zimmerman & Associates, including one for revenue management, Fanning notes. In August 2001, she says, Centegra hired her boss, who has the new title of director of revenue.

Interdepartmental conflict nonexistent

The conflict that often exists in hospitals between admitting and business office staff is virtually nonexistent at Centegra, adds Fanning, who gives a large amount of credit to the QA initiative. "[The business office staff] see us training and retraining and trying to make it right up front," she says. "We now get e-mails from them about our performance and about the money that is rolling in. We're on the same team."

Access staff began wearing their new uniforms — black slacks or skirt with a wine-colored blazer bearing the health system logo — in May, Fanning says. The uniforms are aimed at enhancing the professionalism of the department, she adds, and the reaction from patients has been gratifying. "We've had nothing but compliments."

Along with the new look, Fanning explains, comes an increased emphasis on improving employee skills, with an eye on eventually getting access employees the compensation they deserve.

"They all know how to verify, and they all know how to pre-cert," she notes, adding that the goal is to train all employees in the financial counseling function and ultimately upgrade the position across the board.

Centegra already has a system in place whereby registrars can be promoted to level 2 and then level 3 through certain achievements, Fanning says. Of the 92 access employees, she adds, "there are about eight registrars that have moved up."

Because of the skills required of the pre-registration team, she adds, it is made up entirely of level 3 employees.

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Split in patient access job brings new training focus

Regulatory issues get more attention

When officials at Centegra Health System in McHenry, IL, decided to distribute the patient access workload, they created a new position — system administrator — that former access manager **Liz Kehrer**, CHAM, says is tailor-made for her.

While the new patient access manager oversees daily operations, Kehrer says, she is now able to explore the parts of the job she for which she never had time before.

As system administrator for patient access, she provides technical support for the department, including overseeing a recent computer upgrade, and keeps up with and disseminates information on regulatory changes, Kehrer adds. This includes keeping her staff updated on developments regarding the Health Insurance Portability and Accountability Act (HIPAA), the Medicare Secondary Payer rule, the Emergency Medical Treatment and Labor Act (EMTALA), advance beneficiary notices, and advance medical directives, among other regulations.

Membership in professional orgs help

To keep abreast of the regulatory field, Kehrer says, she keeps memberships in professional organizations such as the National Association of Healthcare Access Management in Washington, DC, and the American Association of Healthcare Administrative Management in Fairfax, VA. She also monitors listservs such as those provided by Phoenix Health Systems in Montgomery Village, MD.

Kehrer belongs to two Centegra teams addressing HIPAA concerns — one on the transaction code set and another on the legislation's privacy rule.

In addition, Kehrer developed and oversees the new patient access-training program, doing the "training of the trainer."

Having a full-time trainer — who works under Kehrer's direction — has given consistency to the process, she says. Before, "training was somewhat hit or miss," Kehrer notes. "I had put together a training manual and a series of videotapes. I would get [employees] started, playing the tapes and reading a series of quizzes on their own."

Kehrer, the access employee who now is the full-time trainer, or another registrar formerly did the hands-on computer training, she adds. Because some registrars used shortcuts or left out certain pieces of the process, Kehrer says, the training was inconsistent.

"The trainees would get frustrated," she adds, "and [the material] is hard to learn to begin with."

Now Centegra has a formal two-week training period for all registrars, conducted by the new trainer, Kehrer says. The curriculum includes instruction in Medicare, EMTALA, and Medicare Secondary Payer rules, she notes, as well as in the provisions of HIPAA.

The trainer also covers such topics as confidentiality, departmental policies and procedures, advance directives, advance beneficiary notices, and customer service, among others, Kehrer adds.

In the second week, employees receive hands-on training on the McKesson-HBOC Star system, which is done on a "fake" computer environment created specifically for testing and training, she notes. The information systems department uses a second copy of Centegra's computer system to receive vendor updates, Kehrer explains. These changes or "patches," which come on a biweekly basis, are then transferred to the testing and training system.

Before, Kehrer notes, she was always frustrated, struggling to perform all the tasks involved in managing a large access services department with little support. "Now I have time to do the part of the job I enjoyed the most and I love it." ■

Centegra's pre-reg team also doing collections

Efforts reduce registrars' workload

When **Deb Fanning** was hired to be patient access manager at Centegra Health System in McHenry, IL, one of her objectives was to establish centralized pre-registration.

That process began in August 2001, Fanning says, when she took four registrars from each of

Centegra's two campuses — Memorial Medical Center (MMC) and Northern Illinois Medical Center — and formed an off-site department at Memorial South, a behavioral health hospital that is an adjunct to MMC.

The pre-registration team is charged with verifying benefits, obtaining pre-certification and making collection attempts on outpatient accounts, she notes. They have had some measure of success with the latter, Fanning points out, collecting $62,000 during their most successful month so far.

Accounts that fall under the team's purview, she says, include any outpatient surgery, procedure, or treatment. "We're doing CT, MRI, ultrasounds, anything cardiac-related, and are even going into behavioral health, social services, and dietary services."

The day before a procedure is to take place, Fanning explains, the account is pre-registered and on the schedule. "Patients go directly to the departments. [Ancillary department personnel] cooperate by getting copies of insurance cards and consent signatures."

Because central scheduling is not yet in place at Centegra, the process works as follows, Fanning says. A person calls the appropriate department, where he or she is scheduled for an appointment and then, ideally, transferred to a pre-registration employee. If the person doesn't have time to give the information, the pre-registration call is made later.

More to come

When construction projects that have complicated operations at both hospitals are completed, she adds, there are plans to add another aspect to the pre-registration process.

"We're going to send out letters to physicians, announcing that we will pre-register anyone who wishes to call [ahead]," Fanning says. Her department will provide physician offices with cards telling patients how to contact pre-registration staff. "If the physician says to the patient, 'I want you to run over to the hospital to get a CBC [complete blood count],' [the patient] can call and let us know before he or she comes to the hospital."

The idea is to eliminate wait time, she says, noting that the effort already has cut the workload for registrars. "They used to do 500-600 [registrations] a month, and now it's down to 250." As the trend continues, staff will be shifted as needed, Fanning adds, with some moving to pre-registration and some to QA.

Those who work in QA, she notes, must apply for the position and will be chosen from the registrars whose accuracy rate is 100%. ■

Health care leaders share discharge delay reasons

Lack of resources, communication cited

What is the No. 1 reason for patient discharge delays? *Hospital Access Management* posed that question to several leaders in the fields of access services and discharge planning. Their responses are below, along with some thoughts on how the problem can be addressed.

Beth Ingram, CHAM, director of patient business services at Touro Infirmary in New Orleans:

"The most common reason is not really a delay in the patient discharge, but a delay in notification of the discharge to bed control or in entry to the system," she answers. "The patient is actually gone, but the system hasn't been updated, so those assigning rooms do not know the room is available.

"The primary reason we find is that the family doesn't pick the patient up at the point of actual discharge. The reasons for this vary: The physician didn't tell them in advance the patient was going to be discharged. They want to wait until after work to pick up the family member, and/or the patient wants to wait until after lunch/dinner to go. Another large contributor is that the physician wants to get the results of a test before the patient leaves, so he will write an order pending the lab test/procedure being performed.

"In the elderly population, we experience delays in getting appropriate arrangements for care after discharge. This issue can be reduced by having discharge planning begin at admission, or at preadmission for the major procedures that are known in advance."

Poor execution, bed turnover problems

Barbara Wegner, CHAM, regional director for access services at Portland, OR-based Providence Health System, says:

"I believe the root problem in discharge delays is a combination of poorly executed processes and problems that plague the bed turnover cycle.

One of the major delays [could be alleviated by] getting the physician's order to discharge earlier in the day.

"At the Providence Health System, we have a group focusing on triggering discharge earlier in the day, to include such things as physicians writing 'pending-discharge' orders the night before to get the process started, flagging pharmacy, laboratory and diagnostic imaging orders to notify these services that the discharge is dependent on timely results, scheduling acute-care managers [discharge planners] to be available on the evening shifts to assist with discharge the following morning.

"In addition, support services must be available, such as 'ride-home' shuttles, arrangements with long-term care facilities / foster homes to accommodate evening and weekend patient transfer, point-of-care testing in the ED [emergency department] and high-acuity units to facilitate timely completion of testing, decision-making triage, and disposition."

Poor 'written/verbal communication'

Kathleen Moreo, RN, Cm, CCM, CDMS, CEAC, co-owner of PRIME Inc. in Miramar, FL, says:

"I think the No. 1 barrier continues to be written / verbal communication. Discharge can't occur because the doctor's order isn't in the chart; the written permission is not obtained; if the patient is going from one facility to another, the approval from the receiving physician hasn't been received; or the approval from the payer hasn't been received. From my training and consulting experience, this seems to occur more often than the fact that community resources don't exist.

"Communication remains one of the most powerful tools — or barriers — to effective health care delivery. Delivery systems spend exorbitant time and funds on developing clinical guidelines and algorithms and revamping information systems while the fundamentals are often ignored. There is no doubt that one of the best tools in the discharge planner's or case manager's toolbox is skilled communication, coupled with effective relationships."

Sandra Lowery, RN, CRRN, CCM, president of CCMI Associates, in Francestown, NH, and immediate past president of the Case Management Society of America, answers:

"In my experience, psychosocial concerns are the No. 1 reason for serious delays. Under that category would be financing issues, decisions related to the environment they would be discharged to, and decisions related to the support services they would need, whether informal or formal. All of these pertain to the psychosocial needs of the individual more than the medical, although certainly both are affected."

Tina Davis, RN, MS, CMAC, senior director, continuum of care, Arnot Ogden Medical Center in Elmira, NY, says:

"The difficulty comes when there is an identified need and no resources to provide for it. It depends on the community you're in and what services are available in the post-acute continuum. In our county, we have a shortage of nursing home beds, so the wait for transfer to a nursing home can be quite long. We also struggle with the Medicare prospective payment system because it becomes difficult to provide home care for those who need it when Medicare won't cover, and these people very often don't have the resources to pay for it on their own."

Adds **Maria Hill**, RN, MS, CMAC, senior consultant with the Center for Case Management in South Natick, MA:

"[The No. 1 reason] is lack of bed availability for Medicare / Medicaid-funded clients in a care facility in the patient's community of residence."

Jackie Birmingham, RN, MS, managing director of professional services for Needham, MA-based Curaspan Inc., explains:

"Here are my top four reasons for delay in discharge from a continuum perspective:

1. knowledge of bed availability in the post-acute setting;
2. locating the appropriate facility for the patient in relation to payer, geography;
3. communicating between hospital and post-acute intake;
4. transferring medical information that can be used for post-acute care."

From **Marne Bonomo**, PhD, regional director for patient access at Aurora Health Care in Milwaukee:

"One of our bigger discharge issues is getting a ride home. We are currently evaluating transportation options, 'meals to home,' and 'medication to home' to help expedite emptying rooms sooner whenever the patient's condition permits. On our new bed management eBoard, one of the indicators is 'patients with discharge orders,' so that social services and utilization [management] can easily see where they need to direct their resources. Also, in addition to length-of-stay teams for each individual hospital, we have oversight length-of-stay teams for our regions. Reduction in length of stay

is one of our key strategic goals."

Lisa Zerull, RN, MS, program director of Valley Health System in Winchester, VA, adds:

"The first thing to consider is the environment, whether it's metropolitan or rural. With [our hospital] being rural, patients can live up to 200 miles away, so transportation is a big reason for discharge delays. We can discharge the patient at 9 a.m., but if the family can't get here until 4 p.m., that person remains in our system. Another reason is physicians waiting until later in the day to discharge patients. We work in an environment where managed care has not penetrated the market, so there is no incentive for physicians to get patients out faster.

"Something that has greatly impacted our length of stay is that we now have a hospitalist on board, so we don't have to wait for a busy family practitioner to make rounds [to discharge patients]. The trend is for family practice offices that are very busy to contract with a hospitalist to care for patients when they are hospitalized." ■

ACCESS FEEDBACK

New MSP time frame prompts reader question

Possible provider risk cited

Liz Kehrer, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL, raises questions about the practicality of implementing a recent change to the Medicare Secondary Payer (MSP) rule.

In a program memorandum dated March 22, 2002, the Centers for Medicare & Medicaid Services (CMS) stated that the frequency with which providers must get an MSP questionnaire signed for reference laboratory accounts now is every 90 days.

Kehrer has suggested to her Centegra colleagues that the subject bears discussing, and welcomes feedback from *Hospital Access Management* readers.

"We don't have a mechanism to know when the 90 days have expired and that the services the patient is receiving for the current visit apply to the MSP questionnaire on file," she points out. Kehrer gives as an example a patient who is having his blood checked every two weeks to measure levels of a drug that controls blood pressure.

"One month after the initial visit for the med-level check, the patient has a lab test to check a wound that is related to an injury," she continues. "The patient cut his leg at a store on a jagged shelf, and so liability insurance should be billed before Medicare."

The looser time frame for the MSP questionnaire, Kehrer says, could put the hospital at risk in such a situation. The result, she adds, could be a heavy fine for not having a valid MSP questionnaire for the wound-check specimen and penalties for fraudulent billing.

More on obtaining consents

Readers at two different hospitals offer feedback this month on obtaining consents, in response to a question in the April issue of *Hospital Access Management* from **Jean Steinbrecker**, admissions manager at Children's Mercy Hospital in Kansas City, MO.

Particularly in the case of direct admits, where her facility's young patients bypass admissions and go directly to the nursing floor, Steinbrecker noted, her staff have had trouble getting the consents signed. Parents are sometimes hard to reach, and the nurses don't believe getting the form signed is their responsibility, she explained.

Ellen Cozart, director of patient financial services at Children's Medical Center of Dallas, says she and admissions manager Suzette Rivera also faced the problem of consistently not getting consent forms signed, for the same reasons Steinbrecker mentioned.

"As part of a performance improvement project," Cozart adds, "we worked with the director of medical records to have the coders check for consent forms on each inpatient chart as it was coded. They did so, and also noted by floor which charts did not have consents. That helped us to narrow down where we had the greatest problems and gave us a base measurement [number of charts with no consents at the time of coding vs. total number of coded charts]."

In addition, Cozart explains, "we requested that the health unit coordinators on each unit

review all charts upon arrival of the patient to see if there were a consent form in the chart." If no consent form is found, she adds, the coordinators call a "consent form hotline" set up to notify the admissions office daily of those patients needing consent.

"An admitting representative checks this voicemail box several times a day," Cozart says. "If a consent is needed, a patient access representative goes to the floor or locates the family for a signature. On some floors, the health unit coordinators have been trained to obtain consent and have [the form] signed by the parent, which is even more efficient."

"With this collaborative effort by medical records, nursing, and admissions, we consistently have less than 1% error rate," she says. "We continue to send out the statistics monthly by unit as a continuing performance measurement."

Shelly R. Seher, registration manager at Bryan LGH Medical Center in Lincoln, NE, says her hospital, which has 500-plus beds, also had a challenge with consent forms. "In the past, admissions staff had to go to the floor and obtain signatures on direct admits. We faced many of the same issues [Steinbrecker] did."

Her department's solution, Seher notes, was as follows: "For those patients who bypass admissions, such as obstetrics patients or those who come by ambulance, we attach a notice to the front of the admission paperwork that requires nursing to collect the patient signature. **(See related story, below.)**

"Medical records performed an audit to track compliance with the new procedure and provide feedback to the necessary managers. We had buy-in from nursing administration to help in this process since these patients bypassed the admissions area."

[Editor's note: Please send feedback on these and other access issues to Lila Moore, editor, at lilamoore @mindspring.com or by calling (520) 299-8730. Liz Kehrer can be reached at lkehrer@centegra.com. Ellen Cozart can be reached at (214) 456-8804 and at ECOZAR@childmed.dallas.tx.us.] ■

Collaboration with nursing getting more COAs signed

Admitters helped in education effort

Bryan LGH Medical Center in Lincoln, NE, has a new process for obtaining patient consent that has significantly reduced the number of cases in which the conditions of admission (COA) form is not signed, according to **Marilyn Klem**, admissions manager.

With the new procedure, there have been only about eight of some 350-400 charts audited each month by the hospital's health information management department where consents were not obtained, Klem says. Most of the patients who didn't sign consent forms were those transported by ambulance or who were in the progressive care unit or the intensive care unit, she adds. "It's either because the patients are critical or because their family is not with them."

In the past, she explains, the patient accounts department sent a "dismissal card" to the nursing floor that would be put on the chart to indicate more information and/or a signed consent form were needed. "If the nurse saw the card, she was to call patient accounts and bring the patient down [to that department] so any missing information or consents could be obtained."

That process, which was very labor-intensive, became obsolete when the hospital moved to patient-centered care and began dismissing patients from the nursing units, Klem says. Later, when the hospital instituted a new preadmission procedure, the entire process changed again, she adds, because of the need to get account information in a more timely manner.

"The verifiers had been going up to the nursing floor and getting the consents at the same time they got other information [for direct admits], Klem notes. "They would spend hours on the nursing floor trying to catch up with the patients to get the information and consents. With the pre-admit process, the patients are contacted by admissions prior to their admission for patient demographic and insurance information. In other words, we try to get all the other information up front so the consent is all that nursing had to get."

With the nurses already doing patient discharges from the unit, admissions management worked with nurse educators to get their help with obtaining the consents, she says. "We put together training material about the COA. Nurses knew how to get consents for surgeries and procedures, of course, but not the general consent, which is a consent to admit and release information and a financial agreement."

Now, Klem adds, for patients who bypass admissions, her staff attach a notice to the front of the admissions paperwork that alerts nursing to collect the patient signature.

"The buy-off was, nurses would get the consent, since they were in the room starting the nursing assessment anyway," she says. "I think [the nurse already being in the room] was the selling point, plus the patient could leave the room and go right out the front door at dismissal."

[Editor's note: Look for a discussion of other instances of how the hospital's admissions department collaborates with nursing in the August issue of Hospital Access Management.] ■

On-line health information helps decisions, study says

Recent studies indicate that the number of people in the United States who seek health care information on-line has doubled since 1998, and that those who search the web for such material say it has an impact on their decisions.

The number of people who go on-line for information about health topics has grown from 54 million in 1998 to 110 million this year, according to a survey by Rochester, NY-based Harris Interactive, a worldwide market research and consulting firm.

Sixty-eight percent of Americans searching the web for health care information say the information they found on-line had some impact on their decisions, according to a study by the Pew Internet & American Life Project in Washington, DC.

That would appear to be good news for hospitals and health systems hoping to increase their visibility and accessibility through use of the Internet. The Pew study found that the typical "health seeker" accesses two to five health sites found through a search engine and spends at least 30 minutes on the search. One-third of the health seekers brings relevant information to their physician.

However, the study found that 73% of health seekers rejected information found on-line for various reasons, including that information appeared too commercial or because they couldn't determine the source of the information. The report, "Vital Decisions: How Internet Users Decide What Information To Trust When Their Loved Ones Are Sick," can be found at www.pewtrusts.com.

The Harris Interactive survey found that the most visited health sites in the United States are for medical journals, commercial health pages, and academic or research institutions.

Some respondents said they look for information only if their physician tells them to do so, but others say they judge the information on their own without consulting their physician. For more information, go to www.harrisinteractive.com. ▼

Hospital Access Management™ (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $435. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $348 per year; 10 to 20 additional copies, $261 per year; for more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $73 each. (GST registration number R128870672.)

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Solucient delays 100 top hospitals report

Citing a delay in data from the Centers for Medicare & Medicaid Services (CMS), Solucient, an Evanston, IL-based health care information services provider, has announced that the 2001 edition of the *100 Top Hospitals: Benchmarks for Success*, won't be published until this fall.

CMS granted an extension of the deadline until the middle of June for hospitals to submit year 2000 cost reports. Until those data are in, Solucient is unable to produce its reports.

Two other specialty reports — one on cardiovascular hospitals and another on the best intensive-care units — also will be delayed until 2003. Solucient also remains unsure of the timetable for its next report for orthopedics. ▼

NCQA, AMGA looking for grant applications

The Washington, DC-based National Committee for Quality Assurance (NCQA), the American Medical Group Association (AMGA) of Alexandria, VA, and Pharmacia (Peapack, NJ) are calling on physician-directed organizations with at least three providers to apply for a safety grant as part of the Safety Collaborative for the Outpatient Environment initiative.

Ten grants of up to $50,000 will be awarded to applicants. Proposals were due by the end of June, and projects should start by September 2002. Organizations with patient safety projects that already are under way are eligible to apply, provided the project has not been completed.

Applications will be blinded and reviewed by a panel of nationally recognized experts who are not employed by AMGA, NCQA, or Pharmacia. Applications will be evaluated with respect to the number of people who could be impacted if the project was widely implemented and the health and fiscal impact if successful; innovation and creativity in the approach; soundness and feasibility of the proposed intervention(s); strength and appropriateness of the evaluation plan and measures; applicability of the project to other practices; and clarity and readability of the application. More information is available on-line at www.amga.org/AMGA2000/QMR/OMC/scope_omc.htm. ■