AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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NOVEMBER 2002

VOL. 10, NO. 11 (pages 161-176)

Hospital bed utilization management team tackles 'bed crunch' problem

BUM team started by analyzing admission sources and space

While many hospitals face the same problem in terms of bed shortages, the solutions to this challenge are as varied as hospitals themselves. Hoag Hospital in Newport Beach, CA, opted to address the problem by forming a Bed Utilization Management Team, or BUM team, that took a systemwide comprehensive approach.

Hoag is a not-for-profit hospital with four centers of excellence including cardiac, women's health, cancer, and orthopedic. "We enjoy a fair amount of success," says **Raymond Ricci**, MD, emergency department chair at Hoag, noting that the hospital ranks first in Orange County in terms of patient choice and is the market leader in admissions with 250,000 visits to the hospital and satellites.

"The problem was fairly straightforward," he says. "We had too many patients and not enough beds." In addition, Ricci says the hospital census was increasing by about 6% per year and the admission rate from the emergency department was increasing at roughly 12% per year. "We also had sicker patients coming to our emergency department," he adds.

In 2001, Hoag had about 70 hours per month of paramedic diversion in the emergency department, compared to 10 or 15 hours a month the year before. That figure represents the number of hours it was closed to paramedics. "This was worrisome," Ricci says. "That was a signal that we were not providing access to the community."

In short, Ricci says, Hoag was being bombarded. Patients were coming in from everywhere, including other hospitals, health maintenance organizations, surgery and same-day services, and direct admissions from physicians. "It felt like we were getting hit from all directions," he says.

When hospitals fail to manage patients properly, patients in the emergency care waiting area often leave, Ricci notes. "When we close to paramedics, our patients go to other hospitals," he adds. "That does not

make patients happy, and that does not make physicians happy." In addition, surgeries are postponed, and the staff are overwhelmed. "They are unhappy and dissatisfied and they want to leave, and that is not a good thing in an era of staffing shortages," he says.

To address this problem, Hoag formed the BUM team with a charter to improve access to the hospital and improve bed utilization and availability. Ricci says the team used a combination of "short-term quick fixes" that could be implemented immediately, along with long-term goals and solutions.

According to Ricci, the composition of the team was a key element to its success. It included people from administration, medical staff, the emergency care unit, case management, social services, nursing, admitting, support services, same-day services, and recovery room. "One of the keys to our success is that all these people had a stake in what we were doing," he says.

The BUM team started by analyzing admission sources and space. "Space is a function of space and the flow of patients," Ricci says. "If your flow is better, you effectively increase your space."

According to **Jackie Jordan**, RN, BSN, Hoag's director of case management, because the overall effort was a complicated process that affected the entire hospital, the BUM team tried to identify certain boundaries. "We tried in a very organized way to look at the process from the time when the physician decides to admit the patient until the time the patient is discharged," she reports.

For example, if a patient is in critical care and must be moved to medical surgery, a bed must be ready, transportation must be available, and the nursing unit must be ready to accept the patient.

Likewise, when a patient is discharged, the physician must make rounds, the discharge order must be written, and a destination must be secured. "Once the patient is discharged, you have to turn the bed around and start the process all over again," she adds.

According to Jordan, the BUM team felt it required some measures to determine how bad the problem really was. "We didn't know how many patients were being blocked from admission or how long it took to turn over a bed," she explains. "We needed to spend some time putting metrics to the process."

One of the first things that the BUM team did was send a group to Virginia Mason Medical Center, a hospital in Seattle that had undergone a bed shortage situation several years before when a nearby hospital closed. "They were running at 99% capacity every day," says Jordan.

To address the problem, Virginia Mason had established an operation center made up of a centralized area with admitting support services and supervisor. "It was very organized," Jordan reports. "It really made you feel like you had a pulse on what was going on in the [hospital]."

Virginia Mason also had established an access nurse who facilitated patient admission, transfer, and discharge. Because the hospital received

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10-20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 contact hours. This program (#0704-2) has been approved by an American Association of Critical-Care Nurses (AACN) Certification Corp.-approved provider (#10852) under established AACN Certification Corp. guidelines for 18 contact hours, CERP Category O.

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many surgical admissions from outside the state, it had to stay on top of who was being admitted and discharged, she adds.

In addition, Virginia Mason had established weekly meetings with managers, supervisors, and charge nurses from all departments in the hospital to address the bed shortage.

Hoag had its own formidable set of challenges. For example, the hospital experienced up to 150 bed cleanings a day, depending on the number of admissions, discharges, and transfers. In terms of bed utilization efficiency, Jordan says the BUM team came up with several issues that it wanted to focus on.

One key issue was patient flow. "We felt that we needed something to help with patient flow and bed control," says Jordan. That meant establishing an infrastructure that did not exist along with a centralized communications system.

"We wanted to engage our physicians in helping us with utilization and discharge because they help move the patients," she adds. "We can't do it without them."

Hands-on experience pays off

The BUM team initiated a bed-cleaning tour, which meant helping support service staff clean the room, turn the beds over, move the equipment, and report to the nursing station. "We found a lot of opportunity by going out and really learning the process," Jordan says. "Unless you go out there and do it, you really don't have an appreciation."

The BUM team also sent out surveys to the medical staff, nursing staff, and various other departments. One problem that surfaced was multiple phone calls to find out the bed status, Jordan says. That was due largely to the bed board, which was a manual system with magnets.

"It is the only place in the house that tells you what the house really looks like, and you have to physically come down and look at it," she explains.

The BUM team also realized it had to establish a communications infrastructure to connect all the departments. In the short term, the team employed some quick fixes such as revising the bed placement guidelines.

"Nursing directors helped prioritize who should get in a bed first and various scenarios," Jordan says. "We also made sure we had daily charge nurse case manager rounds to ensure strong communication about discharge."

The BUM team also developed a patient discharge brochure and advertised an 11 a.m. discharge policy along with a "lunch to go" program designed to encourage patients to leave on time.

Hoag also established a daily bed status report, which was an e-mail sent to about 50 people at 6 a.m. and 6 p.m. "In a very quick way, it tells you the unit, the census, available beds, discharges out or transfers, admits, surgeries, any in the emergency room," she explains. "It is a very quick and easy way to get a picture of the house, and it is communicated and updated twice a day."

According to Jordan, one of the challenges was to get everybody to focus on the entire hospital and realize they are part of a bigger picture. She says the BUM team focused on communications to physicians with specifics on how they could help, such as by using urgent care centers instead of the emergency department when appropriate, making early rounds, and initiating early discharge planning.

"You can write discharge orders the day before so if the patient is stable, the nurse can discharge them the next day instead of waiting for the doctor to come in to write the order," she says.

The BUM team also made a presentation at the general staff meeting, which about half the 800 physicians attended, and reinforced the 11 a.m. discharge with physicians.

In addition, the team added something called the Triad, which was made up of the house supervisor, the admitting supervisor, and the manager of support services. "They came together as a team and really helped troubleshoot at the bed board," she reports. That group met weekly to address issues and work together on a daily basis.

Eventually, the BUM team implemented an automated bed cleaning and tracking system. "We felt we needed centralized viewing of what beds are dirty, what needed to be cleaned, and the status," Jordan says.

According to Jordan, it has been a challenge to employ that system because volunteers, nurses, and support staff all can use it. She says there is currently 40% to 50% compliance but the goal is 80% or 90%. "We are turning beds over faster," she reports. "There are fewer phone calls, and there is less frustration." The team also put viewing capability of the central status in the emergency department and in critical care.

Hoag then established a utilization medical director who implemented physician profiles beginning with internal medicine. The profiles give physicians feedback about high-volume

patients, their length of stay, and their charges, and are risk-adjusted, Jordan says.

According to Jordan, managing "admit to observation" is an ongoing challenge. Because it often is difficult to get physicians to write admit to observations, the utilization medical director sent out a communication on that subject. The BUM team also has an order set including samples of diagnoses that facilitate this process.

Another idea the utilization medical director came up with was a continuing care liaison. Jordan says the manager of social services now is designing a continuing care liaison pilot program. Hoag does not own its own home care, but it made four agencies part of its outpatient development team. "Our goal is to increase the confidence of the physicians in using home care," she explains. In addition to patient surveys, the team surveys physicians about home care utilization.

According to Ricci, because space continued to be a major obstacle, Hoag also revised its emergency care fast-track system. "What we used to do is mix our fast-track patients with medical patients because all the beds were the same," he says. However, the BUM team realized that the fast-track patients' turnaround time could be reduced to the two to three hour range, and if four or five beds were put aside, the hospital could take 30% of its population in the emergency care unit and turn them around in 45 minutes. That boosted the capacity in the emergency department, he says.

Hoag also created an emergency care admit nurse position. Since there was no additional space, the hospital brought the nurse to the emergency care unit and that helped free up the emergency care nurses from doing all the admissions paperwork, he says. It also helped free up the receiving nurse from some of that paperwork. "This was a win-win and increased our virtual capacity in the emergency care unit and up on the floor."

According to Ricci, measurements and goals were critical to the process. "We needed to know where we were [in order] to figure out where we needed to go," he asserts. Ideally, he says the BUM team wanted to know how it was doing on a "moment-to-moment" basis.

The outcomes were broken down into categories such as operational emergency care unit capacity, bed tracking, utilization and discharge, and patient satisfaction. Ricci says the BUM team realized the only thing it could control in terms of the number of patients coming to the hospital was elective surgeries. A forecasting model was developed that estimated the number of elective surgeries, and these data were used to help influence hospital administration in this area.

Since the BUM team was established, Ricci says the emergency care unit volume has been trending up, but the transaction time was flat or diminishing. That is considered an important measure of efficiency, and in this case, an improvement, he adds.

According to Ricci, paramedic diversions essentially were eliminated. The BUM team also implemented an Emergency Saturation Triage, known as a "Code EST," that was used to get everybody's attention regarding bed availability. This is used only when there are patients in the emergency department waiting to be admitted.

Jordan says results were shared with stakeholders to show them how it benefited them. "It was important to have high-level sponsorship," she says. As a result, the CEO was invited to the first meeting along with the CEO and chief of staff. "You could not get more high-level support than that," she asserts. "It really sends a message." ■

Resource center aids discharge decisions

Allows for placement decisions to be made quickly

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

With patients being discharged from the hospital faster and sicker than ever before, case managers as well as patients and their families, must make hurried decisions about post-hospital care. It can be especially stressful when a patient must be discharged to a nursing home or other care setting. The discharge process can be problematic when family members are unfamiliar with the geographic area or various provider options. Families want to do the right thing for their loved one, yet the task of finding an appropriate post-hospital care facility can be daunting.

(Continued on page 173)

Nursing Facility Resource Center Data Questionnaire

Facility Name: _____

Address, City, Zip _____

Phone Number _____ Fax Number_____

TDD Number (if any) _____

E-Mail Address _____ Web Address (URL) _____

Indicate the types of residents accepted:

- ☐ [redacted]es 18-30
- ☐ [redacted]S
- ☐ [redacted]/AIDS
- ☐ [redacted]ntington's Disease
- ☐ [redacted]ltiple Sclerosis
- ☐ [redacted]nal Cord Injury
- ☐ [redacted]so-Gastric/Gastro-Intestinal Tube
- ☐ [redacted]dically Complex
- ☐ [redacted]er: _____
- ☐ [redacted]chiatric (Primary)
- ☐ [redacted]spite
- ☐ [redacted]ntilator
- ☐ [redacted]nderers
- ☐ [redacted]Care
- ☐ [redacted]und Care
- ☐ [redacted]cheotomy
- ☐ [redacted]ygen Therapy Dependent

Special requirements for admission (e.g., religious affiliation, gender, minimum length of private-pay status)

_____

_____

Which of the following services does your facility offer?

- ☐ [redacted]spice Care
- ☐ [redacted]ctious Disease Care (Isolation)
- ☐ [redacted]sical Therapy
- ☐ [redacted]cupational Therapy
- ☐ [redacted]eech Therapy
- ☐ [redacted]ssage Therapy
- ☐ [redacted]Hour Security Guards/Systems
- ☐ [redacted]ked Ward
- ☐ [redacted]chanical Lift(s)
- ☐ [redacted]cured Alzheimer's Unit
- ☐ [redacted]er Alzheimer's Unit
- ☐ [redacted]nderer Alert System
- ☐ [redacted]sident-run Family Council
- ☐ [redacted]e Car Services
- ☐ [redacted]sonal Care Services
- ☐ [redacted]vity Therapies
- ☐ [redacted]er: _____

Which languages are spoken by direct-care staff on daily basis (minimum of 30 hours, 4 days per week)?

- ☐ [redacted]alog
- ☐ [redacted]ntonese
- ☐ [redacted]ndarin
- ☐ [redacted]anese
- ☐ [redacted]ean
- ☐ [redacted]rman
- ☐ [redacted]ssian
- ☐ [redacted]anish
- ☐ [redacted]n
- ☐ [redacted]garian
- ☐ [redacted]sh
- ☐ [redacted]Language (ASL)

Other languages, not listed above:

_____

Dietary Accommodations:

☐ [redacted]getarian ☐ [redacted]r ☐ [redacted]c, describe: _____

Other accommodations of food choices: _____

_____

Staffing:

Average daily number of licensed and unlicensed nurses who are directly responsible for resident care:

	Registered Nurses			Licensed Practical Nurses			Certified Nurse Assistants		
	Days	Evening	Nights	Days	Evening	Nights	Days	Evening	Nights
Weekdays	____	____	____	____	____	____	____	____	____
Weekends	____	____	____	____	____	____	____	____	____
Holidays	____	____	____	____	____	____	____	____	____

Insurance contracts: (list all insurance plans that you participate in)

_____

_____

What else makes your facility great? Add additional comments below:

_____

_____

_____

**** Please include a rate sheet and activities calendar to questionnaire.**

STAFF:

Administrator: _____

Medical Director: _____

Director of Nursing _____

BUSINESS INFORMATION:

Principal Owner_____Since_____

Parent Corporation_____Since_____

NAME OF PERSON COMPLETING QUESTIONNAIRE

Full Name _____ Position _____ Date _____

E-mail Address _____ Phone Number _____

Community CM program targets prison population

Continuum of care maintained for 18 months

An award-winning hospital-based program for prisoners with HIV / AIDS has achieved an incredible 85% completion rate.

The program, called Project Bridge, is sponsored by The Miriam Health Care System in Providence, RI, and recently received the Russell E. Brady Award for Innovative Services Delivery from the U.S. Department of Health & Human Services' Health Resources and Services Administration (HRSA).

What makes Project Bridge so unique — and so successful? "The length of our follow-up, the intensity of the program, and the professional staff," says **Leah Holmes**, MSW, program director and principal investigator for Project Bridge.

"The program is community-based. This means that [post-release], we meet the clients in the clients' environment — home, treatment centers, wherever," Holmes explains.

"We see them at least weekly for the first three months, and then monthly thereafter, and go with them to all their medical appointments to act as facilitators — patient advocates. This helps the patients overcome barriers to adherence with their meds and medical plans," she says.

Project Bridge social workers go into the prison and meet with prospective clients within 90 days of their release date. They formulate a discharge plan, then conduct intensive social work case management for a period of 18 months following discharge. "To my knowledge, this is the only program that follows people with that intensity," Holmes says. "Other programs follow clients for six months at most, and many follow them for only three."

The Miriam, a 247-bed acute-care hospital, is part of the Lifespan health system and has a 76-year history of serving patients with chronic illnesses. "Our specialties include cancer care and cardiac care, as well as AIDS research and prevention," she says.

The foundation for Project Bridge was laid in 1996, when Miriam applied for a "Special Projects of National Significance" grant, or SPNS, which is part of the Ryan White Care Act, funded by HRSA. "They were looking for programs to provide innovative services to under- or unserved populations," Holmes recalls. "Our immunology center has for many years provided HIV specialty care at the state's prisons."

When Rhode Island passed a law requiring HIV testing of all sentenced inmates, Miriam physicians noted that it would be unethical to test without providing good medical care. "Consequently, the state prison system contracted with them to provide that care," she says.

In the early days, the treatment involved "a couple of nurses who worked for the prison who tried some preliminary discharge planning," she notes. "It provided information on referrals with no community-based follow-up."

In the winter of 1996, Project Bridge officials met with potential collaborative agencies, created job descriptions, and began interviewing. In spring 1997, the first case manager and outreach worker were hired and program enrollment began. A referral protocol was created, and the case manager and outreach worker received training at the prison on protocols. As the program grew, client satisfaction surveys were created, technology enhanced, newer, larger facilities were found, and the staff evolved.

In the summer of 1998, terminations were begun for the first clients to have completed the program. **(For more details about the program, see box, p. 168.)**

Today, Project Bridge has two teams of two

Step-by-Step Program Development Outline

The Miriam Hospital's Project Bridge has created a detailed publication on how to create an intensive outreach and case management prison program in your community. Called *Building a Program for Jack: Building Your Program Step-by-Step*, it outlines the creation of a program from needs assessment through client transition procedures. Here is a brief outline of the process:

STEP 1

Coordinate Potential Services
Begin with needs assessment. Be sure to include local service agencies, health care providers, corrections staff, and ex-offenders in the planning process.

STEP 2

Develop Program Design
Tailor the program design to your mission, geographical area, and target population.

STEP 3

Locate the Program and Agency Setting
Create a welcoming environment. Hours of operation, reception area, and private interviewing space all contribute to the degree of safety and respect conveyed to clients.

STEP 4

Hire Staff
Staffing is not the place to cut costs. Consider the goals you wish to achieve.

STEP 5

Work Within the Correctional System
A specific referral mechanism within the correctional facility needs to be developed to identify potential clients. Following institutional rules for inmate visits is essential for a cooperative relationship.

STEP 6

Protect Client Confidentiality and Foster Respect
It is important not to become identified in the inmates' eyes with the correctional system. It also is important that you not be easily identified with an AIDS-specific service or organization.

STEP 7

Conduct the Initial Meeting
Visiting inmates before they are released provides a contact point. Explain how the program can be helpful, but don't promise anything you can't deliver.

STEP 8

Provide Services Following Release
Meeting clients in their homes or other community areas conveys respect and acceptance. Community-based service provision allows opportunities to teach resource management, frustration tolerance, appropriate advocacy, impulse control, and contingency planning.

STEP 9

Be Flexible. Determine Future Activities Based on Client Need
A harm-reduction philosophy is critical to keeping clients engaged in care. Client needs change over time; they may be ready for mental health or drug treatment services that previously had been declined, or clients in recovery may relapse.

STEP 10

Set Up Client Transition Procedures
A well-planned termination strategy is as necessary as a strong engagement phase.

Source: Project Bridge, Providence, RI.

people each — a professional social worker and a paraprofessional — and it has served more than 100 patients.

How effective has the program been? "Of our 100-plus patients, 85% completed the entire 18 months; only three were lost to follow-up — the rest was natural attrition, deaths, moving out of state, or being reincarcerated," she notes. "That, in itself, is excellent for *any* population."

Through chart review, Project Bridge researchers went back after clients completed the program to see how many had been seen for viral load, and 90% had labs drawn. "That's kind of phenomenal," Holmes points out.

At baseline, 60% of the clients had no health insurance. "At the point of program completion, 75% had obtained health insurance, so it pays for itself," she asserts.

Other preliminary outcomes include:

- CD4 counts increased from 423 at baseline to 477 at 24 months.
- There was a drop in viral loads.
- There was an increase in mental health services use by clients who indicated they needed the services.
- There was an increase in the resolution of substance abuse problems by clients who accessed services.

- Clients report decreased difficulty in finding housing.

[For more information, contact:

*• **Leah Holmes**, MSW, Program Director, Project Bridge, 369 Broad St., Providence, RI 02907. Telephone: (401) 455-6879. Fax: (401) 455-6893.]* ■

ED diversions reduced by tight monitoring

Borrowed processes allow real-time reaction

Using a combination of techniques that benchmark best practices from other industries, **Roger Resar**, MD, pulmonologist and change agent at the Luther Midelfort-Mayo Health System in Eau Claire, WI, has gained tighter control on monitoring patient flow and, based on preliminary results:

- Reduced emergency department (ED) diversion hours from 12% to less than 2%.
- Slashed the cost of diversions from about $250,000 a month to less than $30,000.
- Increased from 23% to 40% the percentage of patients who were put to bed within one hour.

In addition, since nurses were given greater control over processes, staff vacancy rates dropped significantly and satisfaction rose, Resar says.

Resar says that a trip to Boston in January 2001 helped set things in motion. At that time, he and his CEO participated in an IHI-sponsored session about hospital flow. "They set up a group of experts to talk about what we might start to do to improve the problem," he recalls. "Our problem was not as acute as the one they had in Boston, but there were still times when the ER shut down, operations were cancelled, and so on."

Resar and his CEO eventually met Eugene Litvak, MD, professor of health care and operations management at Boston University, an expert in the field, and also involved one of their senior vice presidents in charge of nursing in the process.

"What we heard from that group of experts tweaked our interest, and we felt we could probably use some of their ideas," Resar notes. "So we came back and tested some of these ideas."

One realization that emerged early on was that the hospital had no good system for measuring flow through the organization. "We measured bodies that went through in a month or a year, but we had no real-time measurement of flow," he says.

"Every industry, every airport, any kind of large organization that deals with production measures flow at various points; they know where their bottlenecks are and what to do in contingencies. In hospitals, we don't do that at all," he says.

Benchmarking these other industries really opened Resar's eyes.

"My CEO, myself, and several vice presidents went to a local power company that serves a large area of the Midwest," he recalls. "Their office has a huge control board with a panel that runs all around a huge room. They can tell at any time almost down to a single telephone pole how much power is going through, how much is needed, and how much should be changed if there is an increase in demand. It struck me that at any given time in a given hospital, you can't tell what's going on; nobody knows."

Another instructive visit was made at the Minneapolis airport's hub for Northwest Airlines. "They really need to understand flow," Resar notes. "If you notice, airplanes very seldom circle airports anymore before landing. That's because you can't take off from Boston, for example, until you have a landing slot in Minneapolis. In hospitals, we just take patients without knowing where they will 'land.'"

The first thing Resar and his frontline staff did was set up a measuring system that involves all patient floors of the hospital.

"We started out very small, using a pilot area, and did it all on paper before we moved to an electronic [computerized] system," he explains.

The system is based on the 'stoplight' concept, designating red, orange, yellow, or green states of patient flow. "We set it up so that each unit would report on a regular basis, or if something changes drastically, what their color was," says Resar. "If you tell someone you're having a 'red' day, you really don't have to go into a long description for other departments to understand you."

A given unit's color is determined by using a measurement tool — a paper assessment anchored in several objective measures, the end result being the reporting of a color. This is done by the frontline staff.

By April 2001, Resar says, everybody in the hospital was using the system, which was accessed through its intranet.

One of the unique aspects of the changes instituted at Luther Midelfort, and a key to its success, was a mechanism to ensure action. "You can't have a measurement system if people can't act on

it," Resar explains. "The first action we put into place was that when a unit reached a point, usually red, which in the frontline staff's estimation meant they could not accept another patient, they capped the unit." This policy, he says, was called the Capping Trust Policy.

"If you were a frontline staffer and assessed your unit as completely saturated, you were allowed to cap your unit for safety reasons," Resar observes. "This was what Litvak was talking about; the limitation of elective procedures so that you could end up smoothing the artificial variability," he says.

A lot of admissions to hospitals are artificial variations, Resar asserts. "What if I get a call from a doctor at another hospital who says he'd like to send a patient over? In my former life, I would have sent him over. Now, I think about the airport. If I said yes without knowing there was a bed available, the patient ends up in the [emergency department] with no landing spot [and] waits for a bed."

Now, when a patient can't go on a unit, the only way for physicians to have him admitted is to go through an admissions coordinator, who functions very much like an air-traffic controller. "We are a level 2 trauma center; we will bring in a patient if it is an emergency," Resar notes. "But if the patient is 100 miles away, has pneumonia, and needs tests done, they can wait to come in in a couple of hours, not right away," he explains.

The measurement initiative, Resar notes, "allowed the Capping Trust Policy, allowed us to shut down, and forced us to think about how to handle people coming in."

Another key element of the new system is what Resar refers to as upstream evaluation for downstream resource use. It addresses certain facts you must have in hand before scheduling an elective procedure. "If I'm a surgeon doing a procedure that requires an ICU [intensive care unit] bed and a ventilator after surgery, and if I have four operations on Monday and all will require a breathing machine for at least two days, those four will totally plug up the ICU," he observes.

"Instead, I might want to schedule just two procedures for Monday and two for Wednesday, and fill in the operating time with patients who don't need breathing machines. We never did that until now. You can't schedule procedures willy-nilly without realizing what the downstream effects will be," Resar says.

The new system has had a profound effect on nursing morale, he says. "In 2001, we had a nurse vacancy rate running somewhere around 8% to 10%," he recalls. "About six months after we started the Capping Trust Policy, it went down to 1% to 2%, and each unit shows the same dramatic change."

Resar has no doubt there is a connection.

"When frontline nurses get empowered to have a say-so in their work, it improves morale considerably," he asserts.

He also notes that despite the new system, admissions did not drop. "We were able to hire more nurses, but the other thing is this: We found out these nurses and other folks who work in our hospital are dedicated people. We don't see them slacking. Yes, when it gets to the point where they just can't take any more patients, they shut down for a few hours. But they are not taking advantage of the policy." ■

CE *questions*

17. In 2001, Hoag Hospital in Newport Beach, CA, had about how many hours per month of paramedic diversion in the ED?
    A. 10
    B. 35
    C. 70
    D. 85

18. The financial incentive to implement community case management is greater in a market where the level of capitation is low, according to Donna Zazworski, MS, RN, CCM, FAAN, managing partner of Case Management Solutions in Tucson, AZ.
    A. true
    B. false

19. Which of the following is an appropriate response when it appears there may be a dispute about a patient's end-of-life care?
    A. Use case management skills to smooth things over initially.
    B. Ask the risk management department to become involved.
    C. Involve social workers to deal with the family.
    D. all of the above

20. Quality ratings on health care facilities in California can be found at which web site?
    A. www.healthscope.org
    B. www.medicare.gov/nhcompare
    C. www.ncqa.org
    D. www.mapquest.com

Answers: 17. C; 18. B; 19. D; 20. A

ACCESS MANAGEMENT
QUARTERLY

Don't give up: ED copays are 'built into contracts'

Here's the managed care perspective

Many who oversee emergency department (ED) registration have given up trying to collect copays, but this is a definite mistake, according to **Michael J. Williams**, president of the Abaris Group, a Walnut Creek, CA-based consulting firm specializing in emergency services. "Copay collection strategies are a critical tool needed to round out the revenue cycle for EDs," he insists.

Are you missing out?

You're missing out by not collecting copays, Williams says, since they are part of the payment assumptions built into payer contracts. "Hospitals often have inadequate or no systems in place to collect the fees we have negotiated in our contracts, namely the copays," he says.

Copays generally are $25 to $50 for all managed care patients, and there is the potential to collect up to $800 at the beginning of the year when Medicare patients have not yet met their deductible, Williams says. "Only 35% of copays are paid after the ED visit," he adds.

If you increase this to 65%, you'll increase revenues by $150,000 per year, assuming you collect from 15,000 managed care patients with an average copay of $35, Williams says. Some EDs are collecting $25,000 to $100,000 per month in copays that otherwise would be written off, or for which additional costs would be incurred by mailing bills in an attempt to collect, he adds.

Too often, ED managers shy away from collecting copays, fearing violations of the Emergency Medical Treatment and Labor Act (EMTALA), according to **Thom Mayer**, MD, FACEP, chairman of the department of emergency medicine at Inova Fairfax Hospital in Falls Church, VA. "However, the hospital attorneys would be the first ones to tell you there is nothing wrong with doing this," Mayer says, adding that his ED has had significant success in collection of copays.

Copays should be only collected after the patient has been fully medically screened, Williams notes.

Some EDs report unsuccessful experience with copay collection. "This is something we have struggled with," says **Richard Eckert**, MD, medical director of emergency services at University Hospital in Augusta, GA. Instead of doing a medical screening examination at triage, patients are taken directly to treatment rooms where a physician sees them and a disposition is made, Eckert says. "The chart may be made with the financial data before the patient is seen, but since we have the policy that all are being seen and fully evaluated, this does not violate any EMTALA concerns."

The complete chart is made either before or during the medical evaluation process, he says. No copay questions are asked up front. He adds that the ED tried to implement a copay collection process at discharge. "This required additional personnel that we did not have to spare," says Eckert. "Also, very rarely could we collect anything. The patient response was almost always 'Bill me.'"

Here are things to consider about collecting copays:

• **Use "tools" to encourage payment.** Williams recommends use of the following to encourage a patient to pay at or near the time of service:

— **Promissory notes.** These are contracts signed by the patient or financially responsible party provided at discharge.

— **Self-addressed envelopes.** If patients don't have the copay, Williams recommends providing a self-addressed stamped envelope with the patient's account number on it. "If the ED has a financial incentive for point-of-service collections, this payment gets credited to them. Staff are usually highly motivated to pursue this."

— **ATMs and/or credit card machines.** A strategically located ATM machine in the ED is a powerful incentive for patients to settle copays, he adds. "This can be a freestanding machine or a little credit card machine at the desk. It's hard for a patient to ignore or avoid this payment option if

Separate discharge area promotes copay collection

It's not a question of whether you should ask patients for copays, but when, say several reimbursement experts. Here are three strategies:

1. Guide patients toward a separate area upon discharge. Use a separate discharge area for final registration and copayments, recommends **Michael J. Williams**, president of the Abaris Group, a Walnut Creek, CA-based consulting firm specializing in emergency services. "It should be located in an area that is a natural exit from the emergency department (ED). Signage can help with this."

Williams adds that verbal and visual cues to guide the patient to a discharge area are permitted under the Emergency Medical Treatment and Labor Act (EMTALA), as long as the medical screening exam is completed. He suggests giving patients discharge instructions orally, but having them pick up written instructions along with prescriptions in the discharge area.

2. Avoid EMTALA violations. EMTALA requires that there be no delays in the medical screening exam for financial reasons, but having a copay process at the end of the discharge process does not violate this, according to Williams. He recommends the following to avoid violations:

- training and retraining all staff on EMTALA requirements annually;
- educating registration staff on point-of-service collection strategies and tools;
- use of scripting to avoid statements that might be misunderstood by the patient.

3. Discuss copays during registration, but ask patients for payment only at discharge. At Inova Fairfax (VA) Hospital's ED, insurance information is obtained from the patient during registration, says **Melody R. McKeel**, senior operations manager for registration and financial services. If a copay is listed on the card, the registrar says: "I see your insurance requires a $50 copay. Please pay this on your way out at our discharge window, after the doctor has discharged you."

No copays are collected at the time of registration, she explains. "We have the luxury of having a discharge window right at the exit of our ED, which helps us tremendously. This enables us to discuss financial issues after the patient has received treatment." At the discharge window, all demographic information is verified, including address, phone, next of kin, emergency contact, date of birth, Social Security number, and insurance information. "We make sure that everything is properly entered so a clean bill is produced," McKeel says. "The people at the discharge information are at a higher [pay grade] level than the registrars, and their focus is quality collections."

Patients are more likely to be willing to give the copay after they have received quality care and good customer service, according to **Thom Mayer**, MD, FACEP, chairman of the department of emergency medicine at Inova Fairfax Hospital. "We actually end up collecting a lot of copays on the 'back end' of the visit."

The ED currently collects 70% of its copays, McKeel says. "We are striving to get up to 85% by working with the ED staff to make sure they ask patients to stop by the discharge window." There is a system in place to follow up with patients who don't stop at the window, she adds. While checking patients out at the discharge window, the staff takes the opportunity to determine if there is going to be a financial hardship for the patient, says McKeel. "We have several programs we can offer to assist the patient," she says. "If a hardship is identified, we go ahead and complete the required documents at that time." ■

they have their ATM or credit card with them."

• **Determine which group will receive revenue.** At Inova Fairfax's ED, the copay revenue is collected entirely by the hospital, Mayer reports. "We have had some talk of a 50/50 split between the physician group and the hospital. But while it is a fair amount of money, it is something the hospital is doing with the registrar people who are hospital staff members."

• **Evaluate costs.** Eckert recommends evaluating costs if you plan to set up a copay collection system up front. "The added cost of collecting far exceeded our ability to collect. We found that it was simpler to concentrate on moving patients quickly and safely through the ED." Although most physician offices collect copays up front, you cannot do this in the ED unless a medical screening examination has been performed, he notes.

If you decide to do this, an appropriate medical person would have to be used, Eckert says, and if no medical emergency were found, the patient would be refused further use of resources until they paid up front. "This means that you would have to send away both well-insured who didn't have a copay on them that day, as well as the indigent who doesn't pay his bills anyhow, or you would have a two-tiered system, which would be illegal." This would create a public relations nightmare for the facility and a lot of angry people within your ED, Eckert adds. "I do not think that many hospitals are going to allow you to refuse further care to a paying customer." ■

(Continued from page 164)

To help reduce the anxiety inherent in the discharge planning process, some hospitals have developed a resource center for patients and their families. The resource center, housed within the hospital, is stocked with information that can be used to educate patients and their family about available alternatives for longer-term care. Having instant access to this information allows placement decisions to be made quickly as well as more easily. The resource center includes basic information related to location and services, as well as photographs of the nursing homes and other post-hospital care providers in the area. Prepare a notebook of information about each facility. Make sure that information is presented in a uniform manner so that every facility is fairly represented. Patients and their families should be encouraged to make placement decisions based on the facts, not on the style of presentation. To supplement the printed materials, the hospital may wish to offer video presentations of each facility. The presentations, prepared by hospital staff to ensure consistency, provide a visual look at the facility and its surroundings.

Get them connected

If possible, provide families with Internet access so they can view the web sites of facilities that have an Internet presence. Patients and families also should be encouraged to access web sites that contain comparative performance data about nursing homes and other post-hospital care providers.

The Department of Health and Human Services sponsors a web site where consumers can check out performance ratings on skilled nursing facilities participating in the Medicare and Medicaid programs: www.medicare.gov/nhcompare/home.asp. For quality ratings on health care facilities in California, go to: www.healthscope.org. Performance ratings for hospitals, nursing homes, and home health agencies around the country can be found at: www.healthgrades.com. Many state health departments sponsor web sites that provide consumers with performance data on in-state health care providers.

On the wall of the resource center, hang a large map of the surrounding area with the location of each post-hospital care facility clearly marked. Show the distance from the hospital to each facility (in miles). If you include a string or yardstick with a mileage marker, the family can use it to judge the number of miles from their personal residence to the facility. The map and mileage calculation system also helps case managers communicate information to patients and families when recommending a particular facility. Case managers can print out driving instructions to facilities by accessing MapQuest (www.mapquest.com/map) or Yahoo Maps (maps.yahoo.com/) on the Internet.

Patients and their families should be encouraged to use the information in the resource center as soon as it is known that a post-hospital facility will be needed. For instance, people could visit the center before an upcoming hospital admission if they are fairly certain that post-hospital care will be necessary. If your hospital has a formalized pre-admission program, a visit to the resource center might be one of the many stops a patient makes during the pre-admission process. The more people know about their post-hospital care options, the better prepared they will be when faced with discharge decisions.

The resource center can be maintained in the case management office, near the admissions office, or in another location that is convenient for the public to access. Ideally, the facility notebooks and other relevant information are portable so that case managers can take the information to a patient's room when necessary. Often physicians find the information useful in their discussions with patients and families. If demand for the information is high, you may need to create duplicate notebooks and videos and institute a library-style checkout system.

Establishing a post-hospital care resource center is not difficult, but it does take some time. Before proceeding, determine what types of facilities you want to include in the resource center and the geographic region to be represented. If your patients have a choice of home health agencies, as well as post-hospital facilities, consider expanding the resource center to include all post-hospital care options. The resource center also could include detailed information about community support services. Seek out advice from your physicians: What are the common questions they get from patients and families? Try to design a resource center that will answer these questions.

Once the scope of the resource center is defined, it's time to gather information. Send a letter to the administrator of all facilities, agencies, and groups to be represented in the center. Describe your goals in developing the resource center and request their participation.

To assure uniformity in the information obtained from the various facilities, ask them to complete a standard questionnaire. **(See questionnaire, pp. 165-166.)** If photos are requested, provide the administrators with your requirements, e.g., what you want pictures of and the size/format to be provided. If you plan to create a video program about the post-hospital care provider or agency, let them know how you would like to proceed.

Patients and their families will greatly appreciate having all the information about post-hospital care providers in one convenient location. The information will help everyone get through stressful discharge planning decisions. The resource center materials can reduce the time it takes for patients and families to find appropriate post-hospital care facilities. Case managers will find the resource center also saves them time. . . . It's not necessary to answer the same questions over and over again for each patient placement. Everyone, including physicians, will be grateful to the hospital for having an extensive source of information about post-hospital care providers. ■

Community CM models begin to take hold

But incentives depend on reimbursement structure

Community case management is gaining favor among many hospitals, but according to **Donna Zazworski**, MS, RN, CCM, FAAN, managing partner of Case Management Solutions in Tucson, AZ, the incentive to implement a community case management program depends on the motivation of the payer, which is based mainly on the reimbursement mechanism in place.

"If you are in a market where there is a lot of capitation, there is greater incentive to have nurses out in the community performing community case management to prevent hospitalization," she says.

According to Zazworski, if the hospital is receiving a per-member per-month payment from the payer, its motivation is to keep patients out of acute care because it is receiving only a flat fee every month based on the membership they are contracted for.

For example, if an elderly population with congestive heart failure are regular admissions to the hospital, there is a powerful incentive to keep them out of the hospital because they can have a long length-of-stay if they are admitted, she says.

In those instances, she says a community case manager, in many cases a telephonic case manager, can help reduce hospitalization as well as emergency department visits. However, if the capitated agreement is not negotiated properly, the incentive for community case management may be nonexistent, she warns. Other community case management programs can be tied to clinics, Zazworski says. If there is no payer source, the incentive may be simply to help high-risk patients comply with their disease management such as diabetes or asthma, she adds.

Calculating return on investment for community case managers can be difficult, Zazworski says. "It all depends on what your indicators are," she explains. For example, one hospital-based community case management program she implemented for congestive heart failure looked at how much it cost to have those patients in the hospital.

"We saw that we were probably close to $500,000 for a certain subset of patients with congestive heart failure who were under capitation," she reports. However, a pilot program showed that the hospital could reduce readmissions by 18% and first-week readmissions by 40%. ■

How to deal with out-of-state patients' last wishes

Advance directives may not be valid in your state

Here are some scenarios you may encounter as a case manager: A patient has terminal cancer and comes to your city to live out his last days with his daughter. He has a living will, but his daughter is reluctant to follow it. How do you make sure his final wishes are carried out?

An elderly patient is traveling through your state or visiting on vacation and has a heart attack and is unconscious. How do you determine who makes the health care decisions for the patient?

These situations are complicated because the patient resides in one state and is sick in another. And since each state's laws are different, it may be difficult to enforce a living will or health care power of attorney signed in another state, says **Stuart Brock**, CCM, JD, an associate in the insurance, governmental, and tort litigation practice

Be careful in disputes during end of life

When there is an emotional situation, such as a life-threatening injury or illness, family behavior can be unpredictable. As a case manager responsible for coordinating patient care, you could find yourself in the middle of a family dispute on what steps should be taken to care for a dying relative.

If you know the patient's wishes and the family doesn't want them carried out, you, as a case manager, are bound to follow the patient's wishes, asserts **Stuart Brock**, CCM, JD, an associate with the law firm of Womble Carlyle based in Winston-Salem, NC.

That's why case managers should take a proactive approach with patients, especially if they are elderly, to make sure they have advanced directives in place to avoid legal hassles and family squabbles over their last wishes, Brock advises. In the best-case scenario, when a patient is in critical or terminal condition, a case manager will assemble the patient's advance directive documents and put them in the file. If you can't do that, document that you have had the discussion with the patient or the next of kin, he says.

Even if the documents are in place, family members may balk at carrying out their relative's living will. In other cases, you may encounter questions of whether or not the patient has the capacity to make a decision about his or her health care. Your risk when issues of advance directives arise vary with your practice areas, but if you are involved in direct care and the care is not consistent with the patient's choices, you could be at risk and so could your organization.

"We are living in a litigious society, and health care costs are soaring because of malpractice costs and the cost of litigation. Of course, case managers act in the best interest of their patients, but they also must manage the risk to themselves and their organizations. They can't serve their clients if they aren't operating as an entity," Brock says.

If it appears that there may be a dispute about end-of-life care for a patient, immediately ask the risk management department of your organization to become involved. The risk managers can guide you through the legal system and get the courts involved if necessary, Brock says. Involve social workers to work with the family and help deal with issues before they become volatile, he suggests.

Use your case management skills to smooth things over initially and then involve the next level, which is risk management. You don't want to be alone in these situations, Brock says. "Case managers don't want to be making decisions without involving the family as much as they can. Case managers can usually assess early on the family dynamics and can begin the education and diplomacy process," he says.

Keep in mind that case managers are being named among the defendants in more lawsuits and must take steps to protect themselves and their organizations. "In the current litigious state of our societies, case managers, as a part of an interdisciplinary practice, can be affected in many ways by malpractice lawsuits," Brock says. ■

group of Womble Carlyle, a Winston-Salem, NC, law firm. "Case managers have a legal obligation to make sure their patients' choices are honored. It may be difficult to carry out the patients' wishes in these cases, especially if there is a contentious family member," Brock says.

If a case manager in any setting encounters someone from out of state, he or she needs to know that the patient generally is covered by applicable laws in the state where he or she is being treated. During the initial visit, the case manager should ask the patient if he or she has advance directives or, if the patient is unconscious, ask a family member for the documents.

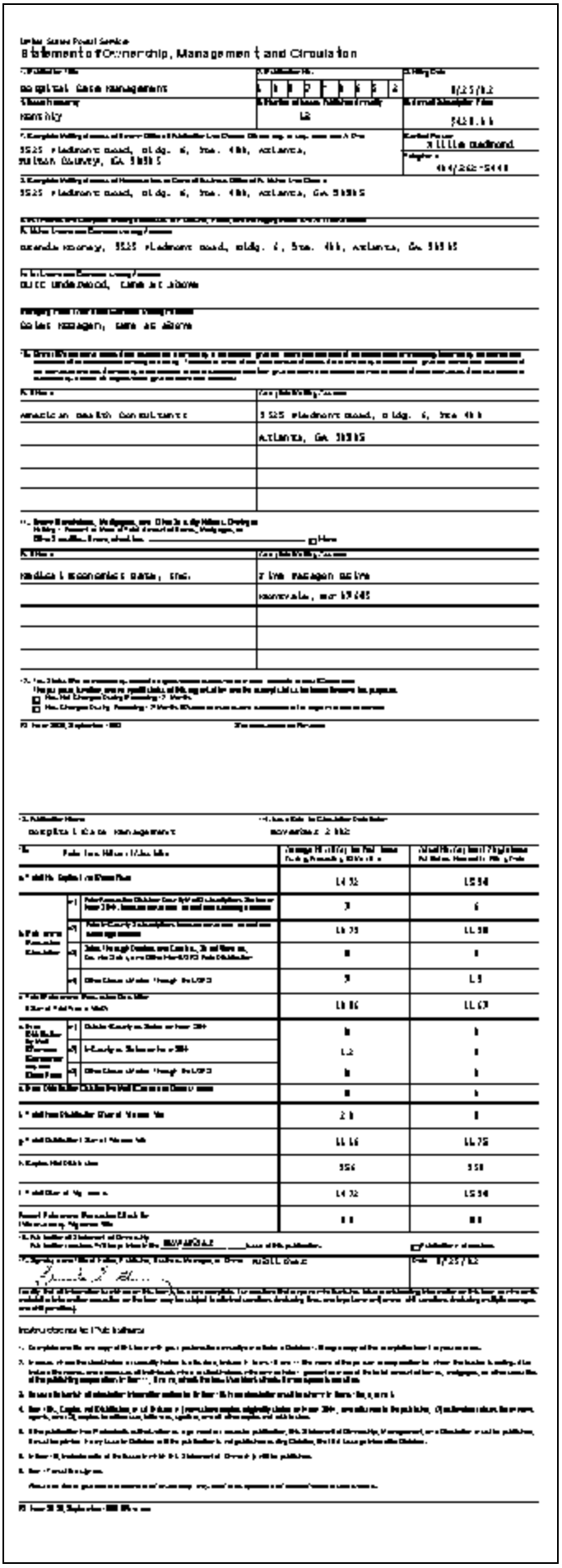
If the documents are at the patient's home, ask to have them forwarded to you. "Case managers must deal with delivering services in a way that is consistent with the patient's best interests. Sometimes, the choices of the patient and the patient's family do not coincide," Brock says.

That presents a problem that is complicated when the patient does not have legally constituted advance directives in place, which could minimize problems with a patient's last wishes.

Brock suggests asking any out-of-state patients whose cases you manage how often they are in your state. If it is likely they may encounter a similar situation, be proactive and educate them about what they need to do to protect themselves, he adds. ■

COMING IN FUTURE MONTHS

- Denial management: The role of the case manager
- How to measure your case management effectiveness
- Emergency department case management
- Dealing with 'frequent-flyer' patients



Statement of Ownership, Management and Circulation

Hospital Case Management

Monthly

American Health Consultants

3525 Piedmont Road, Bldg. 6, Ste. 400

Atlanta, GA 30305

Medical Economics Data, Inc.

Hospital Case Management

November 2002

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

2002 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

How do your salary and benefits stack up when compared to those of your hospital case management peers?

Most respondents earn $50,000 to $80,000

Whatever people do for a living, they all want to know what their colleagues around the country are making so they can gauge just how fairly they're being compensated for our efforts.

Hospital Case Management's annual salary survey was mailed to readers along with the April 2002 issue.

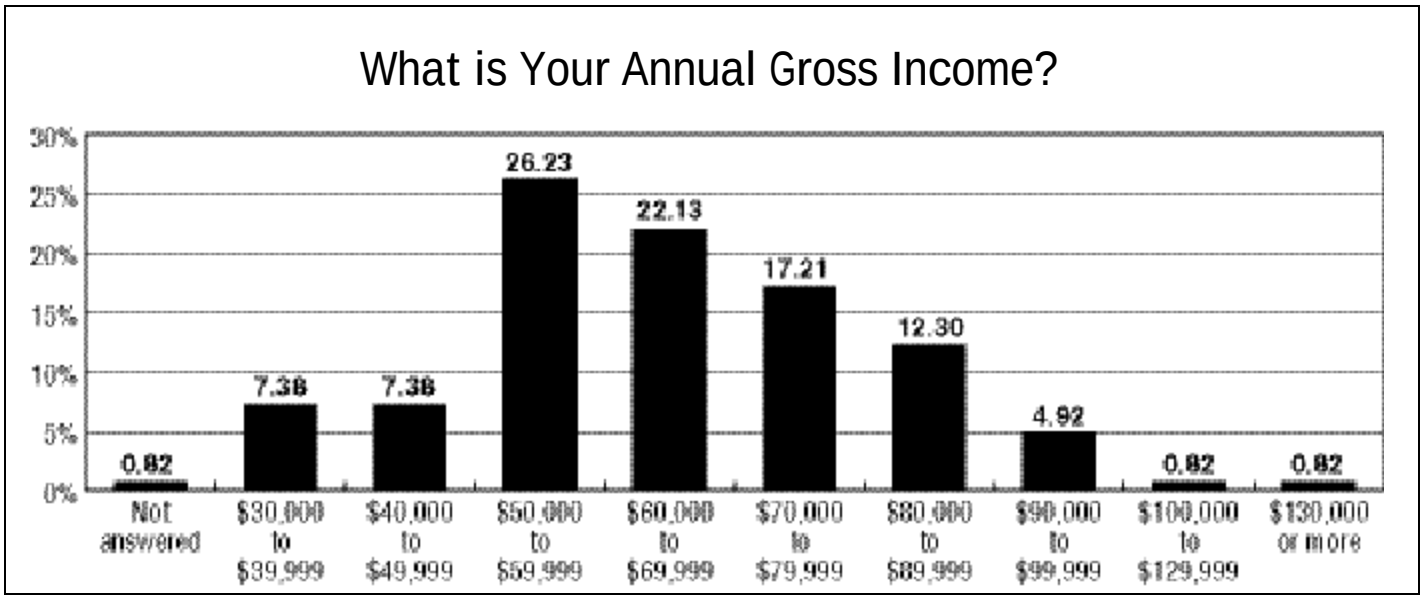
Questionnaires, response forms, and envelopes were inserted into that newsletter. The responses contained no names unless readers wished to include them along with special comments.

The surveys were compiled and analyzed by American Health Consultants in Atlanta, publisher of *HCM*.

We had a solid response — our thanks to all the readers who responded. We've tabulated some results here that we think are of the most interest. What you learn may cause you to take a second look at your situation, but bear in mind that each position is different, and pay scales vary according to geographical location, facility size, experience level, and other specifics.

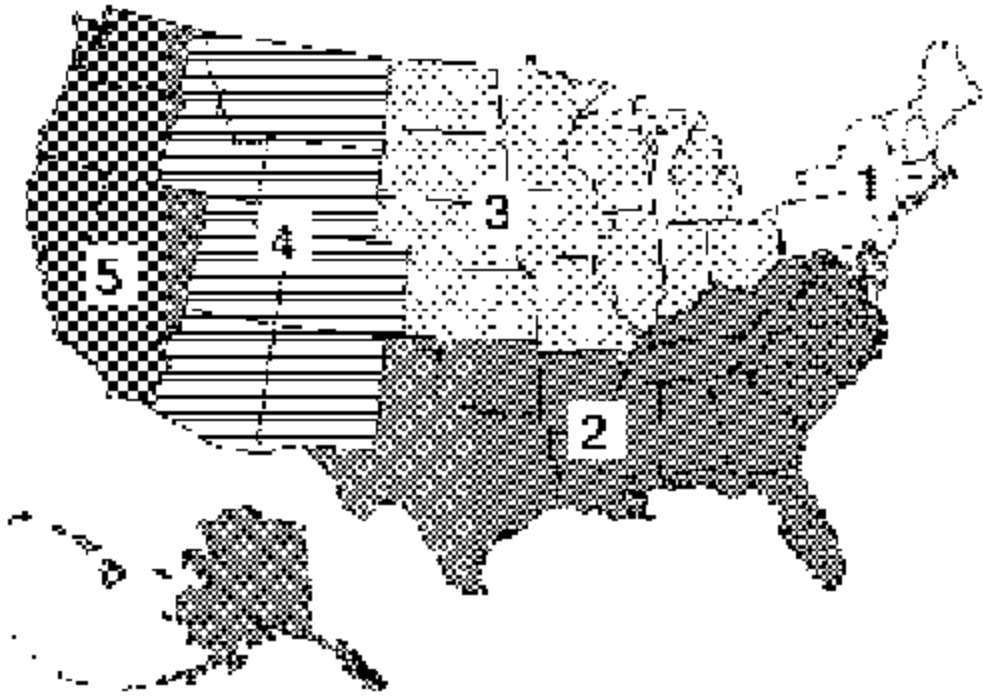
Getting right to the point

As was the case last year, annual gross income for *HCM* readers generally clustered between $50,000 and $80,000. **(See graph, below.)**



Salary by Region

Income	Region 1	Region 2	Region 3	Region 4	Region 5
$30,000 to $39,999	4.35%	8%	8.33%	10%	7.14%
$40,000 to $49,999	4.35%	10%	8.33%	0%	7.14%
$50,000 to $59,999	26.09%	20%	41.67%	40%	14.29%
$60,000 to $69,999	13.04%	22%	25%	40%	21.43%
$70,000 to $79,999	30.43%	16%	12.5%	0%	14.29%
$80,000 to $89,999	8.7%	16%	4.17%	10%	21.43%
$90,000 to $99,999	8.7%	6%	0%	0%	7.14%
$100,000 to $129,999	4.35%	0%	0%	0%	7.14%

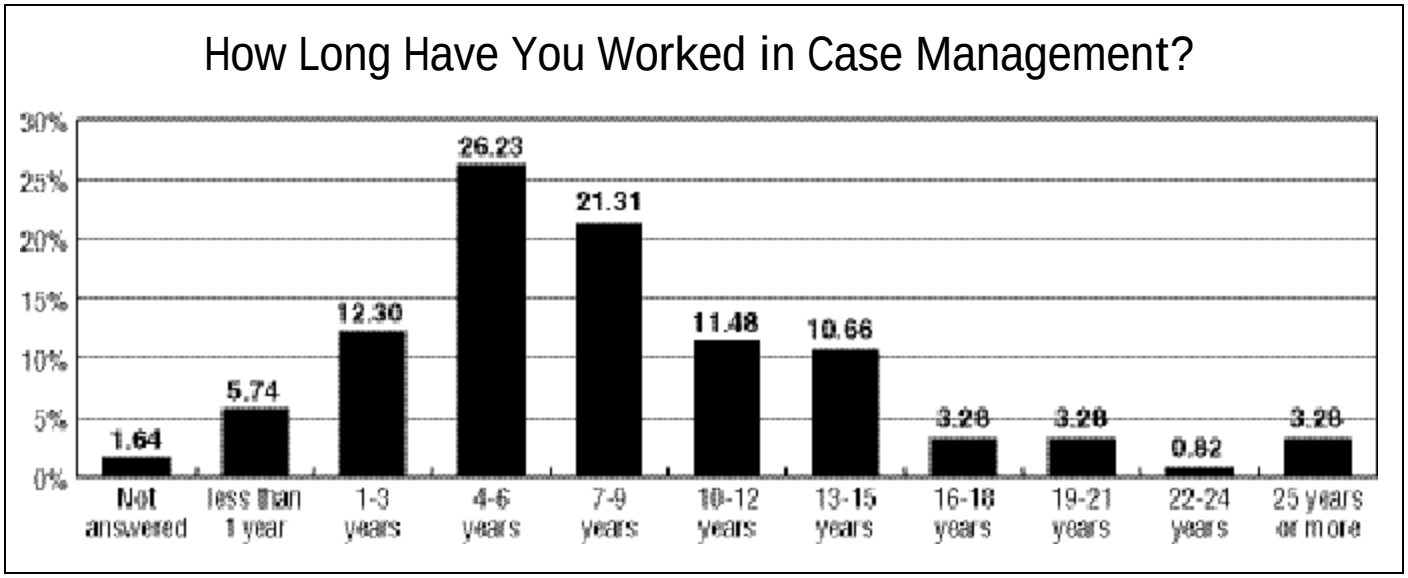


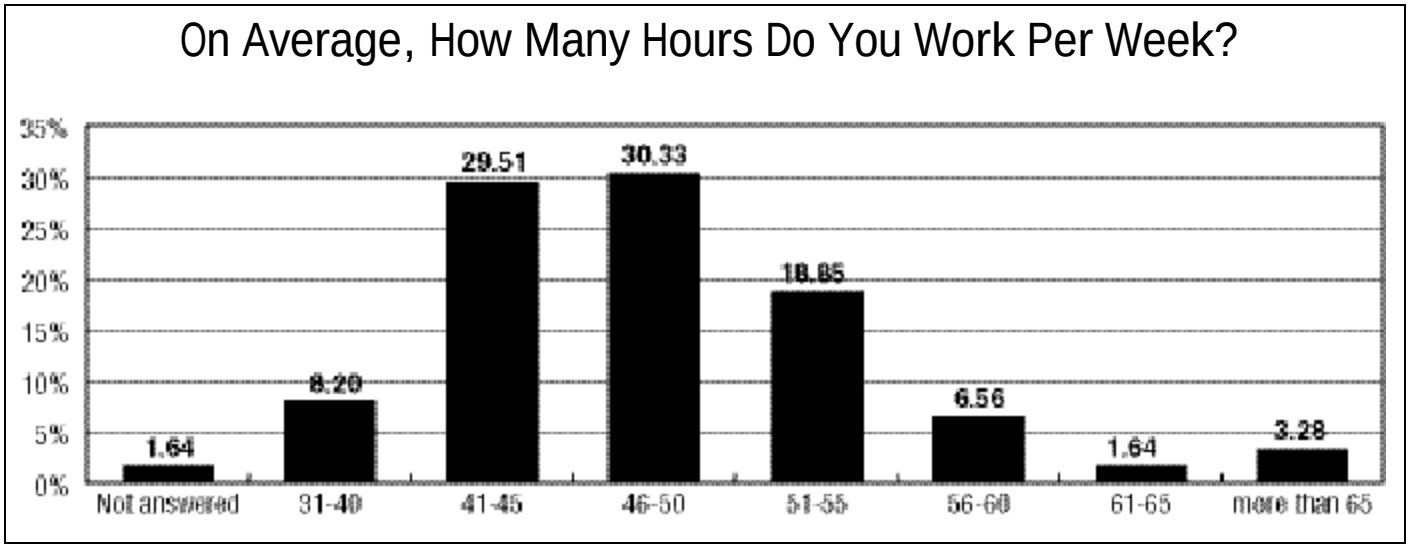
More than one-quarter of respondents (26.23%) earned between $50,000 and $59,000. Another 22.13% earned between $60,000 and $69,999. The third highest group was $70,000 to $79,999, with 17.21% of respondents. Only 7.38% earned less than $40,000, and less than 2% earned more than $100,000.

Most (59.84%) work between 41 and 50 hours per week, although nearly a third (30.33%) work even longer hours. About 37% received a salary increase of between 1% and 3%. Another 34% had a salary increase of between 4% and 6%.

The greatest percentage of respondents, 26.23%, have been working in hospital case management for between four and six years.

Another 21.31% have been working in the field between seven and nine years, while only 10.66% have worked in case management for 16 years or





more. Eighteen percent have worked in case management three years or less. Meanwhile, nearly half (44.26%) of our respondents have working in health care for 25 years or more, and a full 72.13% have worked in health care for 19 years or more. The most common titles are director of case management (60.66%), case manager (12.3%), and utilization manager (8.2%).

Women overwhelmingly in majority

About 93% of our case management respondents are women. About 42% are in their forties, but there are a good number in their fifties (31.15%) and thirties (13.12%) as well.

About 40% have completed at least some graduate work, and another 24.59% have bachelor's degrees.

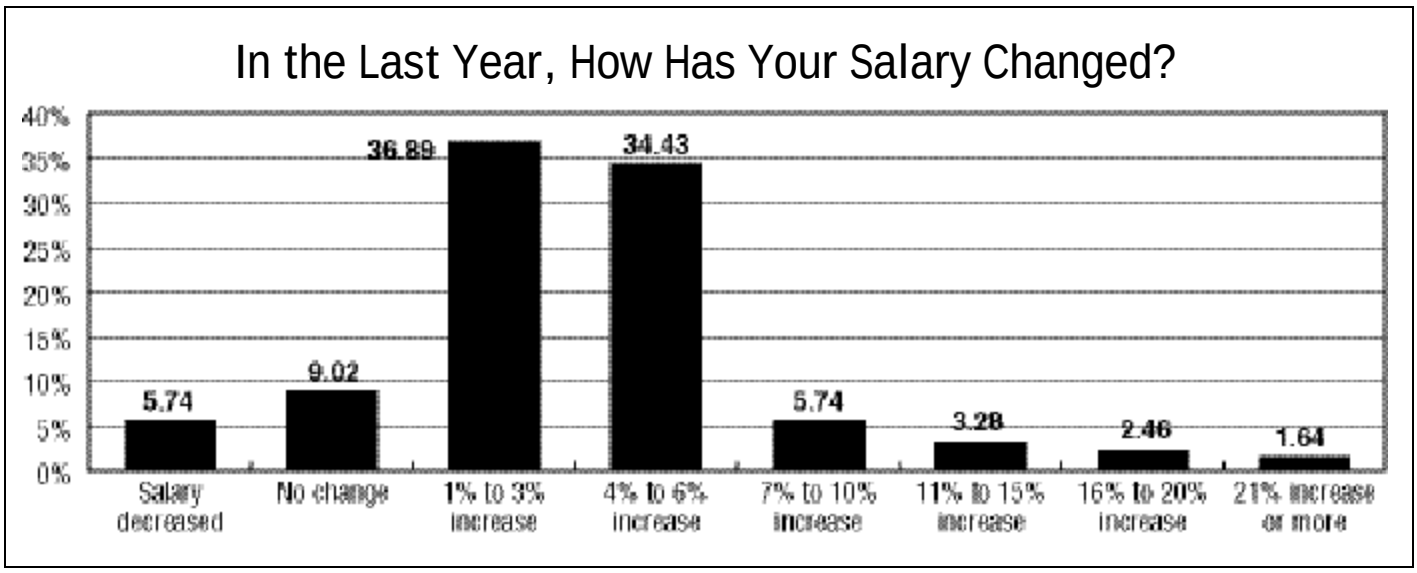
When it comes to the number of people supervised, responses again ranged widely. About 21.% supervise six or fewer people; 30.32% supervise between seven and 15 people; and 37.71% supervise between 16 and 40 people. About 4.9% of respondents supervise more than 40 people.

By the map

A plurality of *HCM's* readers (41.8%) hail from the Southern United States, while 19.67% live in the northern central states running from Ohio on the east to the bread basket states on the west. About 19% live in the Northeast, and 19.68% are from the West or West Coast. **(See chart, p. 2.)**

About 42% come from hospitals in what they describe as medium-sized communities. About 29% are from rural areas, and 13.93% each are from urban and suburban settings.

As usual, most of respondents, 73.77%, work in nonprofit institutions; 13.93% work in for-profit organizations; 5.74% work for state or



county government facilities; and 6.56% work in either federal facilities or academic institutions.

As was the case last year, the highest percentage of our respondents (25.41%) work in hospitals with between 101 and 200 beds. The next largest group, 21.31%, work in hospitals with fewer than 100 beds. Another 18.85% work in hospitals with between 2001 and 300 beds, and 11.48% work in hospitals with 500 beds or more. Less than 1% respondents don't work in a hospital setting. ■

Audio conference tackles HIPAA privacy concerns

The recently released final privacy rule under the Health Insurance Portability and Accountability Act (HIPAA) makes significant changes to the existing regulations. With the April 14, 2003, compliance deadline fast approaching, are your staff receiving the proper training?

Sweeping changes will be needed

The American Hospital Association says implementing HIPAA will require "sweeping operational changes" and will take "intense education of hospital workers and patients."

To help you and your staff prepare, American Health Consultants offers **HIPAA's Final Privacy Regulations: What You Must Know to Comply**, an hour-long audio conference Dec. 4, 2002, from 2:30-3:30 p.m., ET. You'll learn detailed information on changes to the privacy rule, as well as practical methods to implement new procedures within your facility.

Also learn how to successfully manage privacy issues with business associates, and how to spot and avoid costly HIPAA violations.

Do you know what your enforcement priorities are? Do you need real-world examples? Our expert speakers, **Debra Mikels** and **Chris Wierz**, BSN, MBA, will help you understand your responsibilities and identify potential liabilities. All this will allow you to develop a HIPAA-compliance strategy with a rationale behind it.

Mikels is corporate manager of confidentiality for Partners Healthcare in Boston. The Partners system includes some of the largest and most respected facilities in the country, including Massachusetts General Hospital, Brigham and Women's Hospital, and Harvard Medical School. Mikels will provide the practical information and guidance you need to implement a comprehensive privacy policy in your organization.

Wierz is vice president of HIPAA and compliance initiatives for Houston-based Healthlink Inc., a health care consulting firm. She has worked with numerous facilities across the country to prepare them for HIPAA compliance, and now she shares many of her ideas with you.

The cost of the conference is $299, which includes free CE or CME for your entire staff, program handouts, and additional reading, a convenient 48-hour replay, and a conference CD. Don't miss out. Educate your entire facility for one low price.

For more information or to register for the HIPAA audio conference, please call American Health Consultants' customer service department at (800) 688-2421. When ordering, please refer to effort code: **65151**. ■