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## INSIDE



MARCH 2003

VOL. 22, NO. 3
(pages 25-36)

# Hospital's guesthouse and concierge services provide four-star treatment

*It's not just a benefit for the hospital and families anymore; it's a must*

**Cathryne Woolery**, operations manager of guest housing for Providence Health System in Portland, OR, is a woman with a mission.

"My biggest challenge is how to get the word out that guest housing is needed, that it's not just a benefit anymore, but a must. If you don't have a guesthouse, you need some kind of housing program, like a concierge service."

Under Woolery's direction, Providence has both a guesthouse — which she has overseen since it opened five years ago — and a more recently established concierge service, where patients and families making use of the health system's medical expertise can find a comfortable, affordable place to stay.

The Travis and Beverly Cross Guest Housing Center — named for a former Providence St. Vincent administrator and his wife, an active hospital volunteer — was the result of the Sisters of Providence recognizing a huge need and thinking ahead, Woolery says. The center, which is part of patient access services, was modeled after similar establishments on the East Coast, where hospital guesthouses are more common, she adds.

The need is even more urgent today, Woolery notes, as more rural hospitals close and patients seek medical care farther from home. "Traveling costs have become an enormous concern. What happens for those who can't afford a hotel?"

When Woolery had to start turning away or not guaranteeing rooms for people because the guesthouse always was full, she looked for other solutions. She did a survey on what patients want when traveling to the Portland area, especially in an urgent situation, and began working with nearby hotels to see if they could meet those requirements.

"We looked at access to the rooms, whether there was an elevator or just stairs, and if they would offer shuttle service between the hotel and the hospital," Woolery says. "I would go in and look at the establishment,

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to see if it was a place our hospital would be proud to refer someone. They had to come under our standards."

Other issues addressed were whether the hotel was within 10 minutes or three miles of the hospital, and if it would offer a patient rate that was cheaper than its corporate rate, she notes. "That eliminated a lot right off the bat."

In the course of her investigation, Woolery discovered that many of the hotels on lists distributed by the Providence marketing department were not up to par. "I'm certainly not blaming the marketing department, which was trying to be a good neighbor by providing this information, but it was something we needed to stop doing."

Now the list of approved hotels has been extended to include the names of recommended restaurants in the area, she adds. In the past, patients or families looking for a place to eat were dependent on random suggestions from hospital personnel, Woolery says. "It wasn't right or wrong, but it wasn't something that anybody had looked into."

When booking rooms and making referrals, she takes into account the potential guest's financial status, she explains. "If I have one empty room and two people who need to come in, I will take the person without funds [at the guest house] and send the person with financial means to a hotel."

The guesthouse charges a flat fee, but rates are adjusted depending on the length of stay, Woolery explains. "It's more for one night than for two to seven nights, and for every week longer, the cost goes down. If you really have [serious] medical needs, we want to help you the most."

Those who ask for help with the cost undergo a financial screening and may receive assistance, she says, although that possibility is not advertised. As a nonprofit organization, she adds, the guesthouse " is constantly looking for donations" to provide the services it offers.

Woolery's staff includes eight full-time equivalents — three housekeepers and five people who work the front desk, much like hotel receptionists, she notes. Their skills "go way beyond that," however, as they are called upon to do everything from help with third-party billing to keeping a triage eye on their guests, Woolery says.

"They can look at somebody and say, 'I'm going to call the physician and say that person doesn't look well,' or alert people if they see a young girl being treated for an eating disorder bingeing in the kitchen," she adds.

### *Help line spreads the word*

Providence RN, a telephone help line for members of the system's health system, helps disseminate information about the concierge service, Woolery says. As the nurses facilitate a connection between a patient and one of the specialty physicians at Providence, for example, they may offer the 800 number for the concierge service, she adds.

"Some of the rural hospitals that Providence owns are hundreds of miles away," Woolery notes. "We discovered that while Providence RN

**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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**Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.**

**Subscription rates:** U.S.A., one year (12 issues), $465. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $372 per year; 10 to 20 additional copies, $279 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 $78 each. (GST registration number R128870672.)

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THOMSON
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was taking care of finding the best physician for the patient, nothing was being done for the family regarding how to get there and where to stay. There was a need to tie the whole thing together."

Once patients and families find their way to the guesthouse or make use of the concierge service, she says, she is intent on offering the best customer service possible. "I try to run [the guesthouse] like a bed and breakfast. We're much closer to the guest and offer services that a hotel could never do."

Woolery attends annual conferences held by the national organization for guest housing managers, she says, and the newsletter she writes twice or more a year has won first-place awards since its inception.

It would be hard to find someone who would be a better fit for her job. A former admitting manager who used to teach customer service for the Providence system, Woolery had parents who were in the restaurant and hotel business. Her daughter was born with many congenital defects that needed frequent medical attention. "I have spent her lifetime in hotel lobbies, in uncomfortable chairs, not getting to shower, and trying to stay alert to understand what the physicians are saying," she adds.

It was particularly gratifying, Woolery says, when she was complimented on the service at the guesthouse by a patient who had managed exclusive resorts throughout the United States. "He said to me, 'I can't think of a thing you have missed here.'"

*[Editor's note: Cathryne Woolery can be reached at (503) 216-1575 or by e-mail at cwoolery@providence.org.]* ■

# Access employee goes toe to toe with comfort

*Knitting together warmth and customer service*

An employee in the patient access department at Providence St. Vincent Medical Center in Portland, OR, has taken customer service to a new level.

**Joy Lindner**, a retired schoolteacher who works at the information desk at the hospital, part of Providence Health System, oversees a burgeoning volunteer enterprise that provides "toe warmers" to protect the toes of patients with casts on their legs.

At the end of January 2003, Lindner and her crew of knitters had distributed 3,733 of the brightly colored creations to patients at Providence and well beyond, she says. A nurse in the emergency department (ED) at Providence St. Vincent told her about some cast-wearing colleagues who were complaining about their cold toes.

"The yarn store lady helped me devise a pattern, and the two [employees] in the ED loved it," she says. "They thought it would be fun if patients could have them."

Lindner says she did the knitting alone for about six months and then was joined by another volunteer. "We started doing it for Providence St. Vincent ED only, then more people got interested, and we expanded to the orthopedic and fracture clinic. The volunteers told friends, who told friends."

For the first two years, the knitters provided their own yarn, which meant there was variation in the quality of the materials, she says. After Barbara Wegner, regional director for access services, acquainted Providence higher-ups with the program, the project received a healthy infusion of cash, Lindner adds, which meant she could provide knitters with the "wonderful, stretchable yarn" she preferred.

It costs about $1.95 for the yarn for one toe warmer, and takes about four hours to knit one, Lindner notes.

### Growing and giving

An article in the newsletter for hospital volunteers led to more knitters joining the effort, she says, and various donations continue to fund the project. In addition to supplying Portland clinics and EDs, the group has sent toe warmers to Providence hospitals in Medford, OR, and Anchorage, AK.

"[The knitters] have never met all together," Lindner adds, "and a lot of them have nothing to do with the hospital." Finished toe warmers are deposited in a small cupboard at the information desk, she explains.

People in the areas receiving the toe warmers call and order them in different colors, so they can offer patients a choice, Lindner notes, "so we like to have a variety on hand. We really get fancy at Halloween and Christmas."

In addition to her information desk duties, various special projects for the patient access department, and coordinating toe warmer production,

she writes a newsletter for her knitters. In one issue, Lindner dramatically recounts how a serious toe warmer shortage was averted and concludes by welcoming a new volunteer to the group.

She wrote, "You're gonna like this!"

*[Editor's note: Joy Lindner can be reached at (503) 639-3833 or by e-mail at lindner@teleport.com.]* ■

# 'Disposable' handbooks are timely and cleaner

*System's costs cut dramatically*

What if you had 2,000 patient handbooks that needed replacing and virtually no budget with which to do so? That's one of the challenges **Marne Bonomo**, PhD, inherited about a year and a half ago when she became regional director for patient access at Milwaukee's Aurora Health Care.

Patient access traditionally had been responsible for providing the handbooks — placed in patient rooms throughout the multihospital system — but the project hadn't been budgeted, Bonomo discovered. The handbooks, meanwhile, were more than three years out of date, the stock was depleted, and a Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) survey loomed, she notes.

"JCAHO requires that you provide certain information for your patients," Bonomo explains, "and I was afraid that something would be missing, that we would not be compliant."

The existing handbook — a trifold with flip-up laminated pages with text on front and back — was glossy and attractive, but each copy cost more than $20 and quickly became outdated as hospital information changed, she says. It was possible to send updated information to the vendor and have new pages made, Bonomo found, but then she would have been faced with having someone go around to every patient room and insert the new pages.

There were other problems with the old handbooks, as well, she points out. Good hygiene required that housekeeping staff wipe the pages between patient stays, a task that Bonomo describes as "a nightmare" and one that may or may not be done thoroughly each time.

To make matters worse, the handbooks tended to disappear at a fairly rapid rate, Bonomo adds. An estimated five-year supply ran out in about two years, she notes, because patients kept taking them along when they left the hospital.

When volunteers willing to take on the handbook project were not forthcoming, Bonomo enlisted the services of her assistant, Jennifer Huber, and began to brainstorm. "I kept tinkering, looking at costs, asking questions like, 'What would it take to do this in our print shop?'"

She and her assistant began writing copy for the handbook, sending it out to the various departments involved for feedback and piecing together the final product, she says. The text, previously written at a 12th-grade level, now is, for the most part, at the sixth-grade level and conforms to Americans With Disabilities' (ADA) recommendations. Print size and font meet ADA standards for readability, Bonomo adds.

"What we had before was written very nicely, but there were [several] paragraphs about infection control and the health system's values that people had to plow through to get to the gift shop hours," she notes.

## Making it better

The new handbook is disposable — eliminating theft and hygiene concerns – and costs about 13 cents per copy to produce, she notes. It's the size of a folded piece of paper and is teal (the health system's signature color) with black print and a graphic design on the front. Plans are to use a cover photograph on subsequent versions.

If one is facing the book, it is written in English, but if it is flipped over, the information appears in Spanish, Bonomo says. The material is broken into two categories — "While You're Here" and "Going Home" — and includes such topics as ATMs, cell phones, chaplains, flowers and balloons, and telephone translation, she explains. The book also briefs patients on such processes as financial counseling and ordering prescriptions, among many others. **(See excerpt, p. 29.)**

Bonomo says she sent out an e-mail explaining the new handbook to top health system administrators with some trepidation, concerned they might not be happy with its more modest specifications. "I thought they might want some pretty, hotel-like thing," she adds.

So far she has received only positive responses, Bonomo says, including kudos from the president for Aurora's metro region, who called the project

*(Continued on page 30)*

# Going Home

**Cashier**
Hospital bill payments can be made to the Cashier Monday through Friday from 8:00-4:00 p.m.

**Discharge**
Your doctor will talk with you about your discharge date. Please plan to leave the hospital by 11 a.m. on the day of discharge. If you have questions about your discharge, please ask your doctor or nurse.

**Financial Counseling**
Financial counselors can help if you have concerns about how you will pay your hospital bill. They will answer questions about your bill and discuss payment options. If you do not have insurance, they will help you find out if you qualify for Medicaid or other assistance programs.

If you need help, please call the hospital and ask to speak with a financial counselor.

**Nutrition Counseling**
A Registered Dietitian can talk with you to answer questions and help you plan meals. This session requires a doctor's



*Source:* Aurora Sinai Medical Center, Milwaukee.

**Satisfaction Survey**
You may receive a Patient Satisfaction Survey from this hospital asking about your stay. Please fill out the survey and mail it back in the stamped envelope provided. We take pride in the quality and service we provide to you, but we know that there is always room for improvement. We will consider your comments and respond to areas that need attention. Thank you for helping improve our hospital.

**Scheduling Outpatient Services**
After you leave, you may need to return for outpatient follow-up visits. Sometimes these appointments are made for you before you leave the hospital. If not, you may call the hospital operator at (414) 555-5555, who will connect you to the correct department.

**Your Hospital Bill**
We will submit your bills to your insurance company. If they do not pay the entire claim, you will be asked to pay the balance in full.

Please keep in mind that you will receive separate bills from doctors who treat you while you are in the hospital. In some cases, you may receive bills from doctors who have been asked to review your test results, even though you did not see the doctor in person. Pathologists, radiologists, cardiologists, and other specialists will bill you separately from your hospital bill.

If you have questions about any bill, please call the number printed on your bill.

All payments are due in full by the date printed on your bill. If you need special arrangements, please call (800) 555-5555 for help with billing or payment.

"a classic example of making something better, reducing costs, and integrating it in multiple sites." The system's infection control staff were "really delighted" with the disposable books, and at a time when the bottom line is a crucial consideration for health care providers, the cost savings were more than welcome, she notes.

While the old handbooks, which were outdated in six months, cost $75,000 for a two-year supply, Bonomo adds, the cost of the new ones is approximately $9,000 annually.

Adding to the good news, she notes, the handbooks were ready just in time for the JCAHO site visit.

*(Editor's note: Marne Bonomo an be reached via email at marne.bonomo@aurora.com.)* ■

# Do blood alcohol tests fall under EMTALA regs?

*It's not exactly clear, expert says*

Confusion still exists over the question of whether police blood alcohol tests trigger a medical screening exam (MSE) under the Emergency Medical Treatment and Labor Act (EMTALA), according to **Stephen A. Frew**, JD, a web site publisher and a longtime specialist in EMTALA compliance.

The answer is unclear because the Health Care Financing Administration (HCFA), now known as the Centers for Medicare & Medicaid Services (CMS), apparently has mixed feelings on the subject, says Frew, who also is risk management consultant for Physicians Insurance Co. of Wisconsin in Madison.

"HCFA originally said, 'No, this is not a request for medical evaluation or services. It is purely forensic testing,'" he explains. "Then several years ago, the EMTALA desk person at HCFA sent out an e-mail saying, 'Yes, an MSE is required.'"

On that basis, Frew adds, several offices wrote letters or made announcements that blood alcohol levels required MSE. Shortly thereafter, he continues, the EMTALA desk person issued another e-mail that essentially said, "Never mind," because the Office of General Counsel had issued an opinion that blood alcohol tests do not require MSE.

Some providers still are relying on the old letters to support the position that MSEs are required, Frew says, not knowing about the later reversal. But he points out that the matter still is not resolved.

Frew says he recently contacted a CMS office and confirmed that MSEs are not officially required. But he was told, he adds, there is concern that patients presenting for blood alcohol tests may have injuries due to accidents or medical conditions that give the appearance of intoxication.

"This office strongly urged that extensive questioning of the officers and patient should be pursued to assure that there is no medical issue," he says. "They also question whether an intoxicated person can make an informed refusal of care."

### Details, details, details

Given that his experience has shown that CMS "concerns" often translate into citations, Frew adds, he gives this advice:

"We know that with scheduled procedures, there must be logging, but no MSE is required unless the patient gives the slightest hint [he or she] wants to be examined," he continues, or says or does something that suggests the need for an examination.

"Taking the two together, it would seem that CMS will look closely at what the hospital knew, especially if there is a subsequent adverse outcome or complaint, and likely will find a reason to cite [the provider] for not doing an MSE," Frew says. "The answer appears to be to get details of the situation from the police, from nursing observation, and from patient interview to support the decision that there was no apparent reason to give an MSE."

To do that correctly, he suggests, a special form is required. He has designed one that may be accessed — along with other forms that can be used in fulfilling EMTALA requirements — at his web site, www.medlaw.com. ■

# CMS sparks controversy with EMTALA comments

*On-call issue is addressed*

A top official Centers for Medicare & Medicaid Services (CMS) official recently made a startling public statement on another aspect of

the Emergency Medical Treatment and Labor Act (EMTALA), says EMTALA expert and web site publisher **Stephen A. Frew**, JD.

After announcing in a letter to state Medicaid directors at the end of 2002 a new policy allowing states to place certain limits on coverage of emergency services "to facilitate more appropriate use of preventive care and primary care," CMS reversed its position in late January in a letter to leaders of the Senate Finance Committee.

### Significant opposition

The original policy change had generated significant opposition from both Democrats and Republicans and led to the introduction by Sens. Bob Graham (D-FL) and Edward Kennedy (D-MA) of an amendment that would prevent CMS from implementing the change. The American Hospital Association and other hospital and health care organizations sent a letter to all senators urging support for the amendment.

Frew had warned that the worst-case scenario resulting from such a policy change would be that hospitals would be required to continue to provide EMTALA care, but that some states would stop paying for it for several years while the issue was on appeal in the courts.

In rescinding the original letter, Frew explains, CMS advised that EMTALA requires Medicaid patients to receive a full medical screening exam at every ED visit.

But Frew noted in an on-line EMTALA bulletin that a CMS official was captured on tape at an American Health Lawyers Association program saying that CMS will not cite hospitals for failing to have reasonable on-call physician coverage in the ED.

The statement, by CMS official **Tom Baker**, "was in the same spirit of ignoring the clear language of the law and regulations" as the original announcing regarding the treatment of Medicaid patients, he says, speculating that Baker's statement was made "in either a moment of total insanity of with the express intent to completely cripple emergency department operations."

Frew points out that the Office of the Inspector General took a case involving one hospital all the way to the U.S. Court of Appeals to establish the legal precedent that hospitals will be held liable for inadequate on-call coverage and response.

"I could be wrong here, but I think this is another one that will come back to bite CMS," he adds, "but in the meantime, docs and lawyers that hear this may well be tempted to defy call systems." ■

# 'Confusion, fear' reported as HIPAA deadline nears

*It's understandable, access leaders say*

Confusion and fear are the name of the game with a broad range of people and organizations as the April 14 compliance date for the Health Insurance Portability and Accountability Act (HIPAA) privacy rule nears.

That's according to the National Committee on Vital and Health Statistics, a statutory public advisory body to the secretary of Health and Human Services (HHS) in the area of health data and statistics.

Access professionals tell *Hospital Access Management* the emotions described in the committee's findings are more than understandable.

"This legislation is extremely cumbersome," says **Beth Ingram**, CHAM, director of patient business services for Touro Infirmary in New Orleans. "Combine that with some ambiguity and the absence of clear, concise answers from the oversight agencies and we are virtually on our own to implement as we interpret the requirements."

That ambiguity, she points out, "leads to the fear of enforcement and the potential for frivolous lawsuits that plague us in so many other areas."

### A delicate, sensitive balance

**Pete Kraus**, CHAM, business analyst for patient accounts services at Emory University Hospital in Atlanta, wryly notes, "It's our bureaucratic federal government trying to direct the proceedings. So implementation guidelines are unclear and communications garbled. What else would you expect?"

Kraus adds that the HIPAA rules are, "probably out of necessity, very complicated, and the balance between privacy and business efficiency/viability is both delicate and sensitive."

Several witnesses told the committee that less than half of all small providers had made any effort to comply with the privacy rule and that some have no intention of trying to comply.

"One witness reported that some rural

providers have given up on compliance and adopted the position that 'I can't do this — let them catch me,'" the committee reported in a letter to HHS Secretary Tommy Thompson after three public hearings it held to learn about implementation activities of entities covered by HIPAA.

Ingram says she "can certainly understand how the smaller facilities who do not have in-house legal expertise to dedicate to this would be struggling to understand and implement as required. We can only hope that enforcement is fair and recognizes the complexity of issues each organization is confronted with."

She notes, however, that she is aware of a number of organizations that are developing training and implementation packages designed specifically to help these smaller facilities. "Of course," Ingram adds, "this doesn't begin to deal with all the vendor relationships, changes to information release procedures, storage of required data, etc., that remain specific to each organization and its own processes and systems."

"Even more troubling are the potential adverse effects on the health care system," the committee's letter to Thompson continued. "Some witnesses said that some Medicaid and other safety net providers may drop out of the system of providing care to indigent patients because they cannot afford to absorb the costs of complying with the privacy rule, and there is no way to pass along the costs."

## Improve education and outreach

The 18 private-sector individuals on the committee have, according to HHS, distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based health research, purchasing or financing health care services, integrated computerized health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services.

The group said in the letter to Thompson that despite widespread support for the goals of HIPAA and the privacy rule, there are many problems still to be resolved and not much time in which to address them.

The letter suggested that the HHS Office of Civil Rights (OCR) and the Centers for Medicare & Medicaid Services (CMS) improve their coordination of education, outreach, and technical assistance, by working more closely with different industries, states, and federal health care programs.

In particular, it said, OCR should improve its responses to HIPAA-related questions and enhance its web site to help explain the compliance process. And, it said, HHS should recommend that Congress provide financial assistance, through grants, increased reimbursements, and incentives for providers struggling to comply with HIPAA.

## OCR guidance faulted

The committee reported that many witnesses at the hearings said they viewed OCR as not providing adequate guidance and technical assistance. In particular, they "lamented the lack of model notices of privacy practices, acknowledgments, authorizations, and other forms.

"Many witnesses also complained that general guidance was of limited value because of their special industry or professional circumstances. Witnesses conveyed a great sense of frustration that they could not obtain any clarifications from OCR or answers to the questions they submitted via OCR's web site."

Many witnesses indicated to the committee that issues of preemption made compliance much more difficult, costly, and complicated. To determine whether state privacy laws or the HIPAA privacy rule applies to many health privacy issues, covered entities have to obtain a comprehensive pre-emption analysis detailing whether state or federal laws apply.

The committee said the analyses often are lengthy documents that are expensive to research, highly technical, and not binding on any enforcement agency or the courts. Large, multistate covered entities need to have an analysis for every jurisdiction in which they do business, and there is no national coordination on the issue of pre-emption, and state and local efforts vary widely in their degree of completion and the cost to obtain copies. A related issue, the committee said, involves conflicts and overlaps between HIPAA and other federal laws dealing with privacy.

Based on testimony at the hearings, the committee declared that "the lack of clarity on compliance responsibilities, the unavailability of free and authoritative model forms, and the absence of widely available training materials have left many covered entities lacking the wherewithal to come into compliance."

The committee also cited fears of witnesses surrounding HIPAA. Many expressed concern about the possibility of overzealous enforcement by OCR and private lawsuits, both of which were expected to be costly to defend.

Other witnesses said that fear of violating HIPAA has resulted in negative health outcomes, including providers refusing to share patient medical information that would be helpful in treating another patient, and a decline in mandatory or permissive reporting of essential health data to public health agencies, tumor registries, and other entities.

Another key area in the remaining months will be training, the committee said. "Millions of health care workers will need to be trained in the next few months, but there is a shortage of expertise, materials, and funding."

Overwhelmingly, witnesses said that generic training will not work. To be successful, they say, it must be customized by industry, entity, and job description.

"In addition, consumers have received virtually no information about HIPAA, and it will be difficult for them to understand the basis or context for the myriad notifications, authorizations, and other forms with which they will soon be presented. Public education is complicated by consumers' varying levels of education, cognition, and language proficiency."

The committee said it is aware of the limited resources available to the department, and urged that as much as possible be given to OCR so it can accomplish the massive technical assistance, outreach, and education efforts needed in the coming months to ensure successful privacy rule compliance efforts.

*(Editor's note: Hearing testimony and other materials may be downloaded from the committee's web site at www.ncvhs.hhs.gov.)* ■

# Dedicated ED registrar streamlines operation

*Outpatient wait times reduced*

When an infusion of radiology patients into the central registration process at Ridgecrest (CA) Regional Hospital led to longer waits and outpatient complaints, admitting/communication team leader **Monika Lenz**, CHAA, knew it was time for reorganization.

Her solution — dedicating one employee to perform emergency department (ED) registration — not only has dramatically shortened wait times, but has streamlined the jobs of both outpatient registrars and ED clinicians, she reports.

Incorporating radiology patients into the general outpatient mix was done out of necessity about a year and a half ago, Lenz explains, because of space constraints in the radiology area. When the outpatient staff took over the registration of those patients, it also gained the registrar who had been assigned to radiology, she adds. Still, she says, wait times sometimes ranged as high as 30 minutes.

"Our administration is very sensitive to patient complaints," she notes, so the situation became a priority.

Because the hospital only has 80 beds, with 40 occupied beds constituting a big census, Lenz says, there are no registrars who remain on site in the ED. In the past, she adds, ED clinicians could call any one of three different numbers in central registration to alert one of the registrars that there was a patient who needed registering.

If the registrar who received that voice mail message was busy registering an outpatient, Lenz notes, there could be a significant delay. And because any one of three different registrars might handle ED calls, there were breaks in communication, she says.

"[The ED nurse] might say to one registrar, 'I told [another registrar] there was a patient in bed eight. Why hasn't there been a registration?'"

## Efficiency is the result

Under the new arrangement, in place since July 2002, Lenz says, one person is the dedicated ED registrar on any given day. That person wears a beeper at all times and, except during breaks, is the only registrar who responds to the one number that ED clinicians now call when there is a patient to be registered, she adds.

"They leave a message as to which [ED] bed the patient is in. Patients who have been triaged and whose condition is not urgent may be sitting in the lobby," Lenz notes, which also would be specified in the message. Otherwise, the ED registrar goes to the bedside with a clipboard, gets the appropriate forms signed, finishes the paperwork in a room adjoining the ED, collects the medical record, and has the patient wristbands made, she adds.

"The ED registrar has a worksite outside the ED where he or she keeps the files for the day," Lenz explains. "If an ED patient is admitted to the floor, the ED registrar completes the inpatient registration and hand-carries the file to the patient services representative, who is dedicated to [handling] inpatients."

The dedicated ED registrar is relieved from the responsibility of relieving the hospital's PBX operator, which is one of the duties of the central registration staff, Lenz says.

The new system also facilitates the process after normal business hours, when each of the three registrars on duty might be tied up with various task, Lenz explains. "There might be one registrar on break, one on the nursing floor, and one registering a patient, which [in the past] means they frequently might not be able to answer the telephones quickly."

Again, she notes, the beeper system ensures instant communication. "After 5:30 p.m., we don't have a dedicated ED registrar, but one registrar is wearing the pager at all times so the ED can continue to page when a patient needs to be registered," Lenz says. "There have been admissions after hours where the patient is sent directly to the intensive care unit (ICU) by the physician, and ICU needs the account put into the system so they can generate orders."

Although ED staff now love the new arrangement, they at first were resistant to paging a registrar rather than making a direct call, she adds.

"The ED manager and I decided we would push this through, so we had to create some incentives," Lenz says. "When the ED [employees] started calling our telephone numbers, we'd say, 'Sorry, you'll have to page.' They finally got frustrated and started to page."

Outpatient registrars, meanwhile, are delighted with the change, she says. "Everyone knows where they're supposed to be. It's clarified the positions and there aren't any more of those fuzzy lines between jobs."

There also is a lot less waiting time, Lenz adds. "We probably see outpatients on the average in under five minutes."

Although the dedicated ED registrar system will remain in place, she notes, radiology registration will be decentralized again once some additions to the hospital are completed. "Patients don't like having to walk two more halls to get to X-ray."

*[Editor's note: Monika Lenz can be reached at (760) 446-0629 or by e-mail at m.lenz@rrh.org.]* ■

ACCESS FEEDBACK

# APCs, EMTALA concerns pose copay challenges

*Do you have collection strategy?*

Two issues are standing in the way of successful copay collection at her facility and many others, says **Kathy Pajor**, director of patient access services at St. Vincent's Medical Center in Bridgeport, CT. She'd like some feedback from access colleagues who may have developed strategies for addressing either of these concerns.

The first has to do with the vagaries of the outpatient prospective payment system, which became effective Aug. 1, 2000. The system involves a predetermined rate of reimbursement called ambulatory payment classification (APC).

"Collection under APCs at the front end of the revenue cycle process is a challenge," Pajor says. "The self-pay portion is difficult to calculate because it is patient-specific. An example would be if you and I were both Medicare-only patients going in for the same procedure with the same physician, except the physician orders additional tests on you due to multiple diagnoses. You would have a different copay than I would."

Even during the procedure, she points out, the physician could decide to order an additional test that will affect the payment calculation. Or, she adds, one patient might have a reaction to the anesthesia, while another may be in recovery a longer time, also altering the amount of the copayment.

At present, Pajor notes, she is addressing the situation by trying to determine the amount of the average copay for various procedures. "I took a 10% sampling of each major diagnostic test or procedure and calculated an average self-pay portion. Patients will be informed that the required deposit is an approximation and that they will either get a refund or have a small balance to pay."

The problem with that approach, of course, is the back-end work and the cost to produce a bill or process a refund check, Pajor says. Does

anyone have a better way of collecting APC copays at the point of service?

To facilitate some payment collection, she notes, the hospital's financial counselors process applications for Medicare patients who also may qualify for Medicaid coverage.

"If the patient is deemed to be 'over assets,' we will determine an approximate deposit and collect that or a portion — with a payment plan — up front. The medical center is in an urban setting. Our patients who have Medicare-only insurance may qualify for Medicaid, which would cover the self-pay portion we are trying to collect at the time of service."

### ED collection challenging

How do people increase point-of-service collections in the ED, Pajor wants to know, if they're adhering strictly to the provisions of the Emergency Medical Treatment and Labor Act (EMTALA)?

Although she can see the financial and operational benefits of a process whereby a nurse triages the patient, determines his or her condition is not an emergency, and then sends the person along for registration and copay collection, she points out that there is still a gray area regarding EMTALA regulations and collecting money before being seen by the physician.

"Triage involves ranking, the order in which patients will be seen, according to how they present signs and symptoms," she adds. "In the medical screening requirement, which is beyond triage, it's a physician [preferred] who determines if a patient is not in an emergency situation." Access staff cannot delay the medical screening examination to obtain authorization or collect money (42 U.S.C. 1395dd).

"How have other hospitals worked around that [restriction]? What types of business plans have been developed to address this?"

Complicating the situation at her facility — and making collection a particular challenge — is a large unregistered alien population, Pajor notes. Hospitals have to carry the burden of that, and try to be aggressive in collecting self-pay dollars."

*[Editor's note: If you have feedback on this issue, please contact Lila Moore at (520) 299-8730 or by e-mail at lilamoore@mindspring.com.]* ■


## Guidelines issued on smallpox liability

Guidance outlining protections from liability for injury or death arising from the administration of small pox vaccine has been issued by the Department of Health and Human Services.

One section specifies that "hospitals and other institutions that operate as vaccination clinics" are covered by provisions of Section 304 of the Homeland Security Act. It also states that "the . . . declaration may determine that hospitals that designate employees to receive smallpox countermeasures under a state's smallpox plan are considered to be participants in the program and thus are health care entities under whose auspices the countermeasure is administered."

The guidance specifically says that hospitals whose employees are vaccinated elsewhere would be protected by Section 304.

Another section states, "If a work-related injury is covered by a particular state's workers' compensation law, that state law will determine whether the worker can sue any other person aside from the employer."

Meanwhile, reports in the *Los Angeles Times* and other publications have indicated that the number of frontline health care workers expected

**COMING IN FUTURE MONTHS**

- Creating a call center
- Revamping outpatient registration
- Building an access department, the next step
- Access and illegal immigrants
- Gaining perspective on 'the back end'

to volunteer to be inoculated against smallpox had shrunk dramatically, with some states still months away from launching their vaccination campaigns.

A telephone survey by the *Los Angeles Times* of public health officials in 20 states revealed several reasons for the trend, including what the officials said was a lack of additional liability protection for hospitals. Other reasons cited were the absence of guaranteed compensation for vaccinated health care workers who lose time on the job, a growing sense that a smallpox attack is not imminent, and a deeper understanding of the vaccine's risk. ▼

# Federal rule making focus of new web site

Users can find a federal document, read the full text of the regulation and submit comments on-line via a web site launched recently by the Office of Management and Budget and the Environmental Protection Agency.

The web site, www.regulations.gov, is designed to make the federal rule-making process more accessible and enable the public to quickly access and comment on rules from all federal agencies, federal officials have said.

The so-called E-Rulemaking initiative is part of the president's E-government strategy to increase the efficiency and effectiveness of the federal government. ■


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Dept. #Q77750

HIPAA Regulatory Alert

INSIDE



**MARCH/APRIL 2003**

**VOL. 1, NO. 2 (pages 9-16)**

# Fear, anxiety, frustration, and anger on the HIPAA road

*OCR should improve HIPAA responses, report says*

There is "an extremely high level of confusion, misunderstanding, frustration, anxiety, fear, and anger" in a broad range of people and organizations as the April 14 compliance date for the Health Insurance Portability and Accountability Act (HIPAA) privacy rule nears.

That's the finding of the National Committee on Vital and Health Statistics, a statutory public advisory body to the secretary of Health and Human Services (HHS) in the area of health data and statistics.

The 18 private-sector individuals on the committee have, according to HHS, distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based health research, purchasing or financing health care services, integrated computerized health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services.

In a letter to HHS Secretary Tommy Thompson after three public hearings sponsored by the committee to learn about implementation activities of entities covered by HIPAA, the group said that despite widespread support for the goals of HIPAA and the privacy rule, there are many problems still to be resolved and not much time in which to address them.

The letter suggests that the HHS Office of Civil Rights (OCR) and the Centers for Medicare & Medicaid Services (CMS) improve their coordination of education, outreach, and technical assistance by working more closely with different industries, states, and federal health care programs.

In particular, it said, OCR should improve its responses to HIPAA-related questions and enhance its web site to help explain the compliance process. And, it said, HHS should recommend that Congress provide financial assistance, through grants, increased reimbursements, and incentives for providers struggling to comply with HIPAA.

## *OCR guidance faulted*

The committee reported that many witnesses at the hearings said they viewed OCR as not providing adequate guidance and technical

assistance. In particular, they "lamented the lack of model notices of privacy practices, acknowledgments, authorizations, and other forms.

"Many witnesses also complained that general guidance was of limited value because of their special industry or professional circumstances. Witnesses conveyed a great sense of frustration that they could not obtain any clarifications from OCR or answers to the questions they submitted via OCR's web site."

## *Pre-emption issues made compliance difficult*

Many witnesses indicated to the committee that issues of pre-emption made compliance much more difficult, costly, and complicated. To determine whether state privacy laws or the HIPAA privacy rule applies to many health privacy issues, covered entities have to obtain a comprehensive pre-emption analysis detailing whether state or federal laws apply.

The committee said the analyses often are lengthy documents that are expensive to research, highly technical, and not binding on any enforcement agency or the courts. Large, multistate covered entities need to have an analysis for every jurisdiction in which they do business, and there is no national coordination on the issue of pre-emption, and state and local efforts vary widely in their degree of completion and the cost to obtain copies. A related issue, the committee said, involves conflicts and overlaps between HIPAA and other federal laws dealing with privacy.

Based on testimony at the hearings, the committee declared that "the lack of clarity on compliance responsibilities, the unavailability of free and authoritative model forms, and the absence of widely available training materials have left many covered entities lacking the wherewithal to come into compliance."

## *Small providers giving up*

Several witnesses told the committee that less than half of all small providers had made any effort to comply with the privacy rule and that some have no intention of trying to comply.

"One witness reported that some rural providers have given up on compliance and adopted the position that 'I can't do this; let them catch me,'" the letter says. "Even more troubling are the potential adverse effects on the health care system. Some witnesses said that some Medicaid and other safety net providers may drop out of the system of providing care to indigent patients because they cannot afford to absorb the costs of complying with the privacy rule, and there is no way to pass along the costs."

The committee also cited witnesses' fears surrounding HIPAA. Many expressed concern about the possibility of overzealous enforcement by OCR and private lawsuits, both of which were expected to be costly to defend.

Other witnesses said that fear of violating HIPAA has resulted in negative health outcomes, including providers refusing to share patient medical information that would be helpful in treating another patient, and a decline in mandatory or permissive reporting of essential health data to public health agencies, tumor registries, and other entities.

Another key area in the remaining months will be training, the committee said. "Millions of health care workers will need to be trained in

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**Editorial Questions**

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

the next few months, but there is a shortage of expertise, materials, and funding. Overwhelmingly, witnesses said that generic training will not work; to be successful it must be customized by industry, entity, and job description.

In addition, consumers have received virtually no information about HIPAA, and it will be difficult for them to understand the basis or context for the myriad notifications, authorizations, and other forms with which they will soon be presented. Public education is complicated by consumers' varying levels of education, cognition, and language proficiency."

The committee said it is aware of the limited resources available to the department, and urged that as much as possible be given to OCR so it can accomplish the massive technical assistance, outreach, and education efforts needed in the coming months to ensure successful privacy rule compliance efforts.

*(Editor's note: Download hearing testimony and other materials from the committee's web site at www.ncvhs.hhs.gov.)* ■

# HIPAA deadline looms: Is your facility ready?

*If you're not moving, start*

On April 14, covered entities under HIPAA are expected to be in compliance with the new Standards for Privacy of Individually Identifiable Health Information.

"This implies that you have to have trained people in what the policies are," explains **Larri Short**, Esq., of Washington, DC-based Arent Fox, which serves as counsel to the Atlanta-based American Association of Occupational Health Nurses (AAOHN) on HIPAA matters. "Also, you have to begin giving all defined [privacy] rights by April. As an example, AHA's [American Hospital Association's] model notice is 12 pages long — and you have to actually say what you as an organization intend to do."

That being the case, by this time, it would have been prudent to have thought through the regulations, taken a good first stab at appropriate new policies and procedures, and thought of framing what you need to do to make all of this really happen. "If not, you need to move forward as fast as you can to assess the situation and develop policies," Short advises.

## *Not all-encompassing*

The new requirements are not entirely as broad as some might fear. "You only have to apply these requirements to data that can reasonably be linked back to a person," Short explains. "If the information is aggregated, you don't have to worry about it."

In the occupational health context there will be some providers — be they nurses or physicians — who will not be subject to the new regulations, depending on where they work. The three categories of covered entities are health care clearinghouses, health plans, and health care providers. Commercial health insurers, HMOs, and government-funded health care programs such as Medicare, Medicaid, and Tricare are health plans under HIPAA, says Short.

"More occupational health physicians are likely to work in an environment where the rule will apply to them than nurses, but the construct is the same for both," says Short. "Plus, if you don't engage in standard transactions, i.e., filing health claims, coordinating benefits, checking claim status, electronically, the rule doesn't apply to you."

In essence, Short explains, the new regs break down into three major pieces:

- **How providers handle information.** Covered entities are required to have permission to use or disclose individual patient information. It can come in the form of written permission from the patient or, in some cases, it can come in the form of regulatory provisions that allow you to use and disclose information for a designated list of pubic policy issues. Examples would be a response to judicial demands, or to law enforcement.
- **Patient privacy rights.** The use of information will be restricted to the "minimum necessary" to accomplish the purpose at hand, which maximizes patient privacy. "For the first time at the federal level, we have a set of privacy rights for the patient," says Short. "Every patient has the right to access his or her own medical information. You have the right to have your health care provider give you a notice to explain how they are going to use your information."

Some of the rights outlined in the new standards are only a right to *ask;* for example, if an

employee is not happy with what the employer says it will do with the information, the provider can say they can't accommodate the request. If the employer agrees, however, it is then bound to do so.

• **Privacy compliance program.** Covered organizations must appoint an individual who will be responsible for making sure it deals with the first two pieces of the new standards. There are to be written policies and procedures that can be surveyed and, where feasible, technical safeguards and access controls are to be put in place. [The Centers for Medicare & Medicaid Services (CMS) sends surveyors for institutional Medicare providers.]

### *Outside help available*

If you do not have the in-house expertise necessary to bring your facility into compliance, there are a wide variety of resources available, says Short. "You can look to the Office of Civil Rights web site, retain attorneys or consultants, or attend workshops," she suggests.

For example, AAOHN's web site (www.aaohn.org) offers a series of workshops on the topic. There are a number of sources on the Internet as well. "The HHS [Department of Health and Human Services] site [www.hhs.gov/ocr] provides lots of links," Short adds.

The good news is that enforcement will be "kinder and gentler" than it is for some other government regulations, she adds.

"The government will 'seek to achieve voluntary compliance,' with punishment as a last resort," Short explains.

In other words, if all of your preparation is not completed by April 14, you should simply attempt to get it done as soon as possible. "As long as you are cooperative and have made a sincere effort, I don't expect you to get really slammed unless you work in an organization that was certified to participate in Medicare," she adds.

Such organizations are subject to some risk outside of HIPAA through CMS; if they do not meet certain quality standards, reimbursements could be threatened.

*[For more information, contact:*

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# HIPAA Q & A

*[Editor's note: This is the first in a series of periodic columns that will address specific questions related to implementation of HIPAA. If you have questions regarding these areas or others, please send them to Russ Underwood,* HIPAA Regulatory Alert, *American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: russ.underwood @ahcpub.com.]*

**Question:** What are the deadlines for compliance with the HIPAA rules?

**Answer:** There are three sections of HIPAA, each with its own deadline, says **Michael R. Callahan**, partner and head of the HIPAA section for Katten Muchin, a Chicago-based law firm. "April 14, 2003, is the deadline for complying with the privacy rule, and Oct. 15, 2003, is the date to be in full compliance with the transaction code sets," he says. The security rules still are up in the air; and at press time, they had not received final approval. Once approved, providers have two years to comply with the security rules, he adds.

"The difficulty with the unapproved security rules is that many of the security requirements overlap with privacy requirements, such as development of passwords to protect electronic patient information," Callahan points out. This overlap means that an organization must implement some security measures along with privacy measures, he explains. Many organizations are basing their policies and implementing new activities based upon the proposed security rules and hoping they don't change significantly, he adds.

**Question**: Who must comply with HIPAA?

**Answer:** "Any health care provider, billing clearinghouse, or other vendor that submits claims electronically must comply with HIPAA," Callahan says. Even if you don't handle everything electronically, if any part of your process is electronic, such as verifying coverage, you must implement measures to meet HIPAA requirements, he adds. For example, if your program

submits claims information on paper to a billing company that subsequently files claims electronically, your program must comply with the standards.

**Question:** How do I assess my readiness for the privacy requirements?

**Answer:** Start by looking at all of your policies and procedures to see which already comply with HIPAA, says Callahan. Depending on your organization's resources, this step can be accomplished externally with a consultant or internally, he says.

"Many state associations and trade associations have posted information on the Internet to help hospitals and other providers review their HIPAA readiness," he says.

Compare your state regulations to the HIPAA requirements, he suggests. Many state trade associations have undertaken this task to help their members, he says. "In Illinois, we had to go line by line through 324 state statutes and regulations and compare them to HIPAA," he points out.

The good news is that most state regulations are more stringent than HIPAA requirements. "If the state requires more than HIPAA, you follow the state requirements," says Callahan.

As you go through your assessment, be sure to look not only at your policies, but at your actual practice as well, suggests Callahan. "We're finding that most problems are related to sloppiness," he says. The most typical problems in hospitals are:

• **Medical records sitting on a desk or countertop in an area that is open to public traffic.** Records can be left in a designated place for physicians to sign or to enable easy access for nurses, but they must not be left in an area in which nonhealth care providers travel.

• **Computer monitors that display patient information are positioned so that people in the reception area can see them.** Turn your monitors or rearrange desk areas so that only the employee can see the information.

• **A scheduling whiteboard that includes patient names, procedures, or surgeons, on which nonhealth care providers can see names.** Make sure this information is placed in a location that is seen only by appropriate health care personnel.

• **A sign-in sheet contains not only the patient's name but also some other identifier such as procedure or reason for coming into the facility.** Sign-in sheets are fine, as long as they don't contain other information that is related to the patient's medical history, Callahan points out.

**"Be sure your records are linked in such a way that you can find any and all information related to billing, medical treatment, and claims filings. You must be able to pull together all of the information . . . within 30 days."**

As you review your HIPAA readiness, remember that patients may come to you and ask for an accounting of how their protected health care information was used and to whom it was given, says Callahan.

"Be sure your records are linked in such a way that you can find any and all information related to billing, medical treatment, and claims filings," he says. "You must be able to pull together all of the information, along with the log sheet showing how the information was shared, within 30 days."

This requirement means that you may have to find parts of records in radiology, laboratory, pharmacy, quality assurance, accounting, and any number of other areas, he says. You also want to work with your information technology department or consultant to make sure additions can be made easily to the record, because Callahan points out, "In addition to giving the patient the right to inspect records, the patient also may amend the record, so make sure you have that capability in place."

**Question:** Does the signed acknowledgement of notification of privacy rights have to be a separate form?

**Answer:** "Home health agencies are extremely concerned about the amount of paperwork that patients must review, and in some cases, sign, especially during the initial or admission visit. Agency staff members are acutely aware that patients and/or their family members often are ill, tired, in pain, afraid, and worried during the initial visit," says **Elizabeth E. Hogue**, Esq., a home health attorney in Burtonsville, MD. This means that reviewing and signing multiple forms is quite burdensome to many patients, she adds.

The revisions to the final privacy regulations

of HIPAA generally require patients to sign an acknowledgement that they have received an agency's notice of privacy rights at the first service delivery, Hogue points out. Because this is yet another form that patients must sign upon admission, many agency managers would like to include the acknowledgement along with other consent forms so that patients only have to sign once, she says. As long as your process is consistent with the final privacy regulations, you may include the acknowledgement required by HIPAA in a form along with other items, she says.

Here is what the revisions to final regulations published in the Aug. 14, 2002, *Federal Register* say on this subject:

"The department also agreed with commenters that the notice acknowledgement process must be flexible and provide covered entities with discretion in order to be workable. . . . The rule requires only that the acknowledgement be in writing and does not prescribe other details such as the form that the acknowledgment must take or the process for obtaining the acknowledgment.

"For example, the final rule does not require an individual's signature to be on the notice. Instead, a covered health provider is permitted, for example, to have the individual sign a separate sheet or list, or to simply initial a cover sheet of the notice to be retained by the provider. . . . In addition, those covered health care providers that choose to obtain consent from an individual may design one form that includes both a consent and the acknowledgement of receipt of the notice.

"Covered health care providers are provided discretion to design the acknowledgement process best suited to their practices."

**Question:** What information can discharge planners give home health agencies without a patient's permission?

**Answer:** Because gathering complete and accurate information upon home health admission is important, many home health managers are concerned that HIPAA regulations will restrict the type and amount of information that can be given upon patient referral.

Not so, according to Hogue.

"Home care providers should not expect any change in the ability of discharge planners, social workers, or case managers at referral sources to share information with agencies about patients they want to refer once the HIPAA privacy regulations in effect on April 14, 2003," she says.

"First, this is because revisions to the final regulations allow providers to share information for treatment, payment, and health care operations without patients' consent or authorization," she says.

Since hospitals and long-term care facilities, for example, are required by Medicare conditions of participation to provide discharge planning services, sharing information to comply with this requirement may fall within this exception to the need for consent or authorization, she adds.

This same exception allows providers to share information with other providers for treatment and payment purposes, points out Hogue. This portion of the exception also may serve as the basis for sharing such information since the information is necessary for other providers to render services to patients, she adds.

Staff responsible for discharge planning may be concerned, however, about referrals to entities that their employers own or in which they have a financial interest, Hogue says.

Concerns may be based on the section of the revised final HIPAA privacy regulations that state that patients' authorization is needed for marketing purposes, she says.

"Because discharge planners are making referrals to other entities owned by their hospitals, they may be concerned that such referrals constitute marketing services that require authorization from patients," she explains. On the contrary, the revised final HIPAA privacy regulations make it clear that such activities constitute case coordination, not marketing, for which patients' authorizations are not needed, she adds.

"Anecdotally, we are already hearing reports of discharge planners who misunderstand the HIPAA privacy requirements," Hogue says. What should agencies do when the discharge planners in their hospitals misunderstand the above requirements?

"The best course of action may be to go to the designated privacy official within the organization to ask for clarification and communication with discharge planners," she suggests.

*[For more information about compliance, contact:*

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*For resources on compliance, contact:*

• ***The Department of Health and Human Services' Office of Civil Rights*** *has released a new guidance document to address frequently asked questions about the medical privacy rule. Web: www.hhs.gov/ocr/hipaa/privacy.html.*

• ***Workgroup for Electronic Data Interchange****, 12020 Sunrise Valley Drive, Suite 100, Reston, VA 20191. Telephone: (703) 391-2716. Fax: (703) 391-2759. Web: www.wedi.org.]* ■


# Make these changes to avoid HIPAA violations

By **Kathleen Catalano**, RN, JD
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If you don't comply with HIPAA privacy regulations, you may face civil penalties of up to $25,000 for each requirement violated, and criminal penalties of up to $50,000 and one year in prison for obtaining or disclosing protected health information.[1,2]

The regulations are not going to go away. They require a culture change on the part of each and every ED in the way care is rendered.

The best way to avoid problems with HIPAA is to objectively look at your own actions as you carry out your duties in the ED. Here are changes to make immediately:

**• Never use a patient's health information inappropriately.**

You may divulge only information that is necessary to diagnosis or treat the patient. For example, if a delirious patient tells you that he has just gambled away the family's life savings, when giving the report to the next shift, you would relay information about the patient's vital signs, delirium, and the fact that the patient was ranting and raving. The specifics of what were said would not be given.

In the past, a family would bring their aging mother to the ED and wait until the nurse came out to tell them about their mother's condition. That practice no longer will be acceptable. Now, as long as the patient is lucid and able to make the determination, he or she will be asked to designate a member of her family to receive updates.

What if the patient is not in a condition to designate someone? You can assume that it is very likely that the person accompanying the patient to the hospital did so at the patient's request and / or because of a relationship. For example, a husband brings his wife into the ED. His wife is unable to focus and seems confused. It is very likely that the wife would want her husband to be kept abreast of her condition. Again, you should provide only the minimal amount of information that is necessary.

**• Don't allow others to hear confidential information.**

Protection of health information is very difficult in the ED due to cramped space, lack of auditory privacy, and because of the crisis mode that seems to be the norm.

It is easy to forget that there is another patient on the other side of the curtain and that what you're saying is in all likelihood being overheard by many individuals. In many EDs, the patient rooms circle the nurses' station. Thus, if family members stand outside of the patient's room, they often can hear much of what is being said.

Do you talk about one patient when you're in the presence of another patient or the other patient's family? We forget about people overhearing our conversations because we are in the treating mode. As caregivers, we must get a patient's medication stat and there's not much time to think about hushed voices or whether someone is observing what we're writing.

Sit back, watch and listen. Do you hear staff talking about patients in an inappropriate manner?

If you overhear inappropriate statements, you can do several things. You could report it to your nurse manager or ED director, discuss it with the person making the statements, or call your compliance hotline and give a description of what occurred so that the issue will be addressed.

## *Protecting privacy*

**• Make sure that patient information is not visible to others.**

You often can improve the privacy in your ED simply by changing the location of objects. Here are some examples:

***— Computer monitors and fax machines.*** Can a patient's medical records be viewed by people

who have no right to the information? If so, move the computer or monitor to conceal protected information.

If individuals other than caregivers can see documents being faxed, the machine should be moved.

***— Documents at the nurses' station.*** Are papers such as the operating room schedule visible if you stand at the nurse's station? If so, keep materials in a closed folder or turn them over so they aren't visible for all to see.

**• Find a way to protect privacy at triage.**

Do patients have vitals taken and an assessment performed in front of registration clerks? When the patient answers questions posed by the triage nurse, can the responses be heard throughout the ED lobby? A door or curtained windows are good solutions, but they need to be shut whenever a patient is being triaged.

**• Change the flow of traffic in your ED.**

Think about the configuration of your ED. Is there a different way to route families and visitors so they don't hear and see everything that is occurring in the ED? See if you can change that flow. Just because it's never been done, doesn't mean it shouldn't be done.

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### References


1. 45 CFR §160.306 and §160.312 (2000) for Civil Enforcement.
2. 42 USC 1320d-6 (HIPAA Sec. 1177) for Criminal Enforcement. ■


# URAC handbook explains HIPAA security rules

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