Hospital Access Management

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'Seamless' new call center improves facility's customer service and billing

One call can answer patients' hospital and physician billing questions

Providence Health System in Portland, OR, has improved customer service and gained staff efficiency by creating a call center that allows patients to handle physician and hospital billing questions with one telephone call.

"We were trying to find a way to be seamless to patients," says **Jessie Hofstetler**, manager for the inbound call center. Another manager oversees the outbound call center, she adds, but employees now are trained to handle both kinds of calls and are located in the same space.

"When patients called about a bill from a clinic that was Providence-based, we wanted to also be able to address their hospital bills, rather than have them make two separate calls to different places," Hofstetler says. "[Before], they'd say, 'Aren't you Providence?' They couldn't distinguish the difference. They'd go to the physician for an exam, but the labs were sent to the hospital."

The newly cross-trained employees handle the inbound and outbound calls regarding hospital accounts, in addition to the inbound calls concerning physician office accounts, Hofstetler explains.

Staff handling outbound calls for physician accounts still report to the physicians' billing office (PBO), but work in the same space, notes **Kristi Gwilliam**, who, as supervisor for the inbound and outbound call center, reports to both call center managers. Because of their physical proximity, she adds, these employees can now communicate more easily with their hospital counterparts.

Before the consolidation, Hofstetler says, PBO customer services representatives and regional business office (RBO) representatives were in the same building, but on two different floors at opposite ends. The first move, in the fall of 2001, brought together the PBO and RBO staffs handling inbound calls, she adds. In December 2002, the outbound representatives were added.

When the two groups were combined, "everyone had to be able to understand and learn the other's system," she adds. "There are differences

in how the clinics bill and collect accounts, and how the hospital does. We were in a growing phase for a while."

"The greatest challenge we had is that [the PBO] system seemed more cumbersome," Hofstetler notes. "If you have to make changes, like an address update, you have to do it in every account. It just takes longer. You just work at finding the positives in it and at encouraging staff to keep learning, to think of ways to streamline the process."

One example of the streamlining that has occurred, she says, has to do with the "standard note" function on a computerized account.

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Previously, each time a patient called and asked to add an insurance company to the account, Hofstetler explains, the person taking the call would put a note in the computer to that effect, print the screen, and put the printout in the mailbox of someone on the team who handles insurance matters.

"This past year, we created a standard note, so that the employee [taking that information] would punch in a number that meant 'add commercial insurance,'" she says. "That would come out on the note [in the system]."

"Maybe 30 or so of those [notes] are put on a report that is distributed each morning to the people on the [insurance] team and they work from that report," Hofstetler adds. "It saves time and money."

Other numbers, Gwilliam points out, are punched in to indicate Medicare or Medicaid coverage. "It keeps staff from having to distribute these reports, and from having to figure out who they actually go to. There's no more paper passing."

Keeping track

As employees have become more proficient in being able to move around both computer systems, Hofstetler says, efficiency has increased. When the new center was created, there were about 25 full-time equivalents, she adds, "but we're now down to 20."

Because the call center is open from 8 a.m. to 8:30 p.m. on weekdays and from 9 a.m. to 1 p.m. on Saturdays, she adds, there are both full-time and part-time employees.

To encourage gains in efficiency, Hofstetler says, the call center tracks the total number of calls received each month — around 35,000 — as well as the number of "two-in-one" calls, where more than one issue is resolved.

In the latter cases, she explains, staff may take a proactive approach. "We get about 500 calls a week where the person wants to know what the bill is with the hospital, and [the customer service representative] checks the physician accounts and sees an outstanding bill there as well."

Using a telephone tracking system, the center monitors how long an employee stays on a call and how long he or she spends in after-call work, such as making a notation on the account or looking up the explanation of benefits to see if a payment was posted correctly, Hofstetler says. "We look at whether the rep is doing that within three

to five minutes."

Each customer service representative is expected to handle between 80 and 110 calls per day, she adds. "We measure all the calls they transfer and say they can't resolve, Hofstetler notes, and those can't exceed a certain percentage. We track all abandoned calls [when the caller hangs up before reaching a representative], which also have to be kept to a certain percentage."

If the percentages aren't acceptable, she says, "we pull other staff to fill in. There is a certain standard we have to meet."

There are five employees from throughout the office — from the RBO and PBO staffs — who are trained on both computer systems and able to fill in when needed, Hofstetler says. "Their [normal] roles are, for example, a collector for the physicians, or a member of the credit team, but if there are 20 calls in the queue, and the call center staff can't keep up with the volume, these are people we can call."

"We've really worked hard," she adds, "at having the offices buy into the belief that the first priority is the customer."

Space promotes communication

While the customer service representatives were used to working in cubicles with high sides, Hofstetler notes, those walls have been lowered in the new space to facilitate communication. "[Employees] can see what everyone else is doing, and they can see [managers and support personnel]."

"We created an elevated area within the new call center, called the support area, for the support team," she adds. "When the staff are handling a tough call and need more help, all they have to do is press a button and a member of the support team is available and will help them get through it."

That support person — who, if necessary, may be the team trainer or a supervisor or manager — will either walk over to the employee's desk or access the same account and communicate by telephone, Hofstetler explains. "Somebody is always available to help staff. That's really our goal — to support the team."

One of the big pluses of the call center, she points out, is that there are customer service reps who are bilingual in a variety of languages.

Callers who are having a difficult time resolving their concerns with the first responder because of language difficulties are asked if they would like to have someone help them in their native language, Hofstetler adds.

Spanish, Vietnamese, and Chinese speakers are available, she notes. "We want to find a Russian [speaker], but it's hard." If the appropriate rep is on another call when a person needs the language help, the information can be left on a voice message box, Hofstetler says. "We check it whenever the light is on."

"If a person calls in and can't understand and only speaks Chinese, the rep will say something very simple, like, 'I will transfer you to a message, you talk,'" she adds. "We will return the call within 24 hours."

Future plans for the center include using an automated coaching tool that will help reps find ways to increase efficiency, determine which screens to select, and say things more effectively, Hofstetler notes.

From the beginning, she points out, her job has been made easier by a "great team who was willing to experiment. They had a lot of fun with the challenges, and would push each other to meet a goal. We would celebrate at the end."

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LOS reduced as system hones case management

Bed management, discharge initiatives cited

It's been more than a decade since Lehigh Valley Hospital and Health Network in Allentown, PA, took its discharge planning and utilization management functions and created a resource utilization department with a single director, says **Susan Lawrence**, MS, CPHQ, administrator of quality and case management.

The "forward thinking" exemplified by that move — unusual for its time — continues to the present, she adds, paying off in continually decreasing lengths of stay (LOS) for the 750-bed system, which includes two hospital campuses in Allentown and another in Bethlehem.

Such present-day initiatives as daily bed alerts, emergency department (ED) case management, and an express admit unit for direct admits from physician offices continue to streamline health

system operations, Lawrence explains.

Medicare patients at Lehigh Valley have an average LOS of 5.3 days, she notes, while the average medical-surgical LOS is 4.5 days. The latter figure becomes more impressive, Lawrence points out, when one considers that it includes level-one trauma patients, and those in the neonatal intensive care (NICU) and burn units. Babies in the NICU, she adds, can have stays of from 20-40 days.

After the creation of the consolidated department in 1990 — now known as the case management department — the next pivotal move, Lawrence says, was the decision in 1994 to combine the roles of the discharge planner and utilization management (UM) nurse, so that each could perform the other's duties.

"We were implementing patient-centered care, and we began looking internally at how we could adopt some of those principles and have less people interacting with the patient and the medical records," Lawrence says. "We looked at the job descriptions of the discharge planner and the UM nurse, and thought we could put those roles together completely."

The department conducted a three-month pilot, with two discharge planners and one utilization nurse performing the blended function. The findings, she says, were that the discharge planners were able to review the medical record, assess severity of illness and intensity of service, evaluate the clinical information and report all this to the insurance company to get authorization.

Conversely, Lawrence says, the UM nurse was able to assess patient needs at the time of discharge and develop plans for post-hospital care, whatever those might be.

"It took about 12 months to cross-train everyone, so it was the end of 1995 by the time that was fully implemented," she notes. "We began to see some improvements in LOS, and we did not see an increase in denials."

With the combining of the two functions, Lawrence adds, the person handling the case is "constantly aware of whether the patient meets the criteria to be in the hospital and can immediately act to implement the plan. You're not repeating, so you save time."

The health system has used that model ever since, she notes, and in 1999 began an additional focus on decreasing LOS. "We tried to refine the role of case manager and increased the recognition of that role throughout the organization."

With LOS reduction identified as an important priority, Lawrence says, the health system began holding weekly multidisciplinary meetings, pulling in representatives from such areas as respiratory therapy, pharmacy and radiology. "We were able to bring to the surface what some of the delays were."

In response to those findings, she notes, the health system implemented Saturday thallium stress testing and weekend physical therapy, among other changes.

"We have also done some studies to evaluate what's impacting LOS, and we've identified a lack of short-term skilled nursing facility (SNF) beds," Lawrence says. "We happen to have a hospital-based SNF unit, but it was only staffed for 32 beds. Once we demonstrated the need, it was opened up to 42 beds. It's licensed for 55, so the data are evaluated periodically to see if we need to recruit more staff to open more beds."

Daily bed alerts instituted

Because Lehigh Valley's registration process is fairly decentralized, there is no admitting department, Lawrence explains. Direct admits are sent from the front door to the nursing floor, and staff there perform registrations, she adds. ED registrars report directly to the ED management, Lawrence notes, and there is a person with the title of director of support services who supervises registrars in certain areas.

The director of bed management — a function that, in many hospitals, is part of access services — handles one of Lehigh Valley's LOS initiatives, she says. That individual, who supervises a department that is staffed 24 hours a day, seven days a week, issues daily bed alerts when the hospital gets to certain occupancy levels.

"They will send pages, messages out to various members of the staff, including case managers," Lawrence says. "What that tells us is how many people are awaiting beds and what kind of beds they need. It helps the staff to prioritize."

Like many other providers, Lehigh Valley has looked closely at ED operations in its efforts to relieve overcrowding and increase bed capacity, she notes.

Case management in the ED was instituted after a pilot program showed that it avoided a significant number of inappropriate admissions, Lawrence says. The ED case manager is able to arrange skilled nursing facility admissions for non-Medicare patients directly from the ED, she adds. "Even the placement of Medicare patients

can be facilitated if they don't need acute care."

The ED case manager also has helped a great deal in placing patients in assisted living homes, setting up home care, and ordering durable medical equipment, Lawrence adds. "[The case manager] has been a really good resource."

A project called Clockwork ED, she says, "implemented a lot of processes to improve ED efficiencies, but we realized that many of our inpatient operations were impacting [the ED's] ability to send patients to the floor."

"If a patient is not discharged from the bed, [another patient] can't move up from the ED," Lawrence adds, "so we created a large group called 'Growing Organizational Occupancy,' which we call GOC."

That team, which began meeting in October 2002, has chartered a number of subgroups, she says, to focus on various parts of the hospitalization process.

The team's first mission was to look at the mechanics of discharge, Lawrence notes. "If you're being discharged and going home with your family, how do we get you to the front door?"

"Then we had a group that looked at how to get a bed cleaned as quickly as possible," she says. "We identified that the patient may have left the building, but we were unable to turn around [the room] quickly enough. Part of it is the nurses are busy with other patients, and cleaning the bed is not a top priority."

A number of recommendations have been made to streamline the process, she notes, including a proposal for automating discharge paperwork. Under this plan, Lawrence explains, physicians would generate orders on the eve of discharge that would notify physical therapy, radiology, and other pertinent areas to move toward getting the patient out by 11 a.m.

"We're trying to increase the percentage [of early discharges] from 8% to 20%," she says. "To make that happen, we're working on a communication campaign targeting patients' families, all caregivers. We want to communicate a consistent message that — like a hotel — once you're discharged, it's time to go."

The idea, Lawrence says, is to eliminate such scenarios as telling a patient at 9 a.m. that she's been discharged and having her say, "I'll call my husband and have him pick me up. He gets off at 4 p.m."

"It's about changing everyone's mindset," she adds, "informing patients that as soon as they're discharged, our goal is to make the bed available for the next patient."

Another plan has to do with establishing centralized dispatch for external transport, Lawrence says. At present, individual case managers call various ambulance companies to secure arrangements for their patients, she notes. "We're proposing they call a central number and have [a dispatcher] call and make arrangements."

Although case managers still would be making the same number of calls, Lawrence says, this method gives the hospital more control over the time that a patient is being picked up and allows prioritizing.

"If we need an ICU bed more quickly," she adds, "we could prioritize an ICU transfer out earlier in the day. If case managers are making arrangements independently, they're all vying for the same time."

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Mission: Improve, expand centralized outpatient reg

Training and coding issues addressed

When **Anthony M. Bruno**, MPA, MEd, took on the challenge of creating an access department at Philadelphia's Presbyterian Medical Center, part of the University of Pennsylvania Health System (UPHS), one of his first hires was **Colette Howerton**, who became the new manager for outpatient access services.

A longtime employee of UPHS, Howerton most recently had worked as an admissions supervisor in another of the system's hospitals.

Her mission, explains Bruno, who has been describing the process of building an access department from the ground up in a series of interviews with *Hospital Access Management*, was to improve and expand centralized outpatient registration services.

Basically, Howerton has taken a two-pronged approach, he says, providing registrar support in high-volume outpatient registration areas while incorporating small ancillary areas into central outpatient registration.

When she arrived, she says, all outpatient

registration was centralized in one area. Patients endured long waits, and registration quality often was poor, mostly because registrars had not had the training they needed to handle the coding associated with different medical specialties, she adds.

The health system's orthopedic clinic in particular was plagued with problems, Howerton notes. "Patients were getting tied up in a queue in central registration. The complaint was that patients were waiting an hour to register to get an X-ray, another hour to see a physician, and then another hour in radiology."

Shifting a registrar from central registration to the orthopedic clinic, after providing the needed training, Howerton says, greatly reduced that turnaround time. Not only is the chief of orthopedics ecstatic at the streamlining of that operation, Bruno notes, but removing those patients from the central registration queue dramatically shortened the wait time in that area.

Howerton also has put in place a preregistration system for patients undergoing magnetic resonance imaging, CAT scans, and gastrointestinal services so they don't wait so long when they arrive for their appointments, she says. Another benefit is that technicians also spend less time waiting for patients to come back to the treatment area, she adds.

The Philadelphia Heart Institute (PHI), part of UPHS's cardiology operation, was another area in which Howerton stationed a registrar, he says. The new registrar joined an existing employee who had been splitting her time between registration and tech work, Bruno adds. "The problem there was poor registration, bills not going out the door correctly and being rejected."

The specialized coding required for the echocardiograms and other procedures done by PHI created a particular challenge, he notes, because registrars had to recognize unacceptable codes and contact physicians for changes or clarification.

So that the repositioned registrars wouldn't be missed as much from their original posts, Howerton says, she rearranged work schedules and lunch breaks to ensure more coverage during high-volume times of day.

"The people there were sufficient, but it was a question of how and where to use them best," explains **Raina Harrell**, who recently joined UPHS as manager of revenue cycle. "One of the first people [Bruno] hired was a manager for training, and [that individual] immediately trained the registrars from A to Z. Once it was decided that a person needed to go to an area, specialty training was created for that person."

That training included classes as well as computer modules with accompanying tests, she adds.

"We have also taken away registration duties from smaller ancillary areas such as phlebotomy and physical therapy," Howerton notes, because the registrations performed there are more generic.

Results have been dramatic, she says. "The overall error rate for inpatient and outpatient registration is going down. Before, it was at 7%, but since the new fiscal year began July 1, 2002, it's gone down to 2%, with a 1% rate for outpatient registrations."

Future projects, Howerton adds, will include a reorganization of the flow of information in the infusion center, where chemotherapy is done.

That area presents it own set of challenges, Harrell notes, including the need to authorize coverage for six months, or six visits, for example. Questions to be addressed include:

- How long is the pre-cert good for?
- How many referrals are needed?
- Is this one covered?

Registrars must check to make sure a patient's insurance coverage hasn't changed, she adds, because with drugs priced at $2,000, mistakes can be particularly expensive.

Looking at systems issues

Harrell, who has worked with Bruno at three other health care organizations, will provide another piece of the access department puzzle. She has been charged, she explains, with overseeing the improvement of all systems — anything having to do with the flow of information. "You can't make the system work if the people don't work."

Her focus, explains Harrell, will be on cleaning up errors created by staff or the computer system. She is addressing, for example, the categories of DNFB, which refers to patients who have been discharged but not sent a final bill, and OPEX, or outpatient exception reports, which cover outpatient accounts that have not been billed.

"What I've been doing is looking at things that didn't go the way we expect them to go," Harrell says.

"There are IDX systems in our physicians' offices that interface with the hospital's SMS system, which is for patient registration and billing," she notes. "We have a Cerner system

in our laboratory for order entry and results placement, and a PA RAD system in the radiology area. That's a real challenge. The information going from registration to billing is another challenge."

"What I do is look at the flow of information from one area to another," she adds. "I will monitor error reports, transmission control errors, and see what information passes from one system to another, and if that system is matching information correctly. Did the same information come out when passed to the next system?"

The larger the DNFB and OPEX reports, she points out, the fewer the bills going out the door, the higher the days in accounts receivable, and the less money that is being received in a timely fashion.

"We've developed monitoring tools for those two reports, to see how well the hospital is doing, and if [the efforts] bring down overall billing days," Harrell says.

"There will be a report that can be shared on a weekly basis with the different departments that affect the fact that the bills are not dropping," she says, "like medical records, the business office, or any area that does charge entry, like the ED. It will say, 'These are the accounts you have been holding. Can you help us correct these errors?'"

Many of the tools she is using were developed using Microsoft Excel, and are put on a shared drive that can be accessed by employees in any of the affected departments, Harrell notes. "They can be downloaded, so you don't have to hand them out to people."

"We're also working on a project that has to do with reimbursement for hospital-based physicians," she says. "When a patient has a physician office visit and the physician practice is owned by the hospital, there is a charge the hospital can recover."

The process is called "maps," Harrell explains, "because we 'map' what the physician did, the charge for which the hospital can bill. We get paid and give the physician the money, so we pay them either way. We need to make sure we get reimbursed for all of the services."

Maintaining the chargemaster, she points out, is crucial to making sure the hospital is being correctly reimbursed. "We're in the process of going over the accounts of the past year and a half and looking at, 'Did we bill appropriately? Did we get reimbursed?'"

The problem that can occur, Harrell says, has to do with the charge that the physician office enters. "They put a code into IDX indicating what they did — whether it was just an office visit or something additional — and the information has to come across to SMS and match to a code saying, 'This is what the hospital gets paid.'"

As with anything else, she adds, codes are not good forever.

"The real thrust for [Harrell] will be the revenue cycle," Bruno notes, "looking at reducing our days in accounts receivable and bringing in more cash. The maps project is a huge one and should be bringing in a lot of revenue."

"We're also looking at level one claim edits," he says. "When we put claims in through software called EZ Claim, it edits out any errors so we're not sending faulty claims on to the payer."

If the registrar puts in the insurance plan code and the identification number doesn't match, Harrell adds, the software will catch it.

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Veteran AM moves to collections, gets results

Impact of registration mistakes are clearer

Martine Saber, CHAM, had something of an awakening when she assumed her current position as director of support services for HCA Healthcare in Palm Harbor, FL. As a longtime patient access director, she was well aware of the importance of "getting it right" at the point of registration, and worked diligently with her staff to foster the creation of accurate claims.

But it was only when she became immersed in the world of "the back end," Saber says, that she realized exactly how far-reaching and time-consuming the effects of the simplest registration mistakes could be.

Transposing figures when entering a patient's

Medicare number, for example, recently resulted in Medicare denying a claim because the patient couldn't be identified, she notes. "The patient was very angry with us, called us names, and now we have to rebill Medicare. They eventually will pay, but instead of within 45 days, it will be more than 100 days. It was a really simple thing, human error, but it took away from the wonderful care that the patient received at our hospital."

In another instance, a patient gave two insurance cards to the registrar, who entered all of the information for the primary insurance, but left out some of the data on the secondary insurance, Saber says. "We bill the first insurance, but on the second we don't have everything, so we call the patient, who doesn't respond. Eventually, we send the bill to a collection agency."

It was only when the unpaid bill showed up on the patient's credit report, interfering with the purchase of a house, that her department discovered that the patient had moved, changed telephone numbers, and never got the messages pertaining to the secondary insurance, she adds. Remedying the situation involved rebilling the secondary insurance and removing the bill from the patient's credit report, Saber explains, not to mention the time it took to get to the bottom of the problem.

Even more problematic was a case in which the registrar inadvertently enters the medical record number of another patient who happens to have the same name as the person being registered, she says. All the charges go under the wrong person's Social Security number and eventually make their way to a credit report, which again surfaces when the person is trying to buy a house.

That mistake necessitated the wrongly billed person having to come to the hospital and prove she did not receive the care cited on the bill, Saber says. "She had to give us her signature three times, show her driver's license, and we even had to go so far as to look at the medical histories of the two different patients."

"I know how these mistakes happen, but I never realized how much of an effect they have," she adds. "Now I work with our patient access directors and try to feed back to them these kinds of errors. If not, they never know."

One of the biggest errors has to do with constantly changing insurance plan numbers, Saber says. "Sometimes it's because the registrar chose the wrong number, sometimes it's because we put in the wrong number. There are a lot of things that can also go wrong on the back end."

"When we do identify that it is a registrar error, we tell the patient access director so he or she can start trending," she adds. "I'm seeing a reduction in errors. It's wonderful to see how they want to work with us, how we can help each other, when we feed back to them in a nice way."

'A different way of helping'

The switch to patient accounting was "a wonderful career move for me," Saber says, partly because it makes her work experience better rounded. "I have to know a little bit about everything, about billing, collections, refunds, overpayments, underpayment."

The change suits her desire for less stress, fewer hours in the car, and more regular work hours, she explains, but it also offers a new kind of job satisfaction.

"It's a different way of helping" patients, Saber says. "On the front end, the patients are in front of you and they're sick, and you want to hurry and get them into a bed. On the back end, you still have to have compassion. Sometimes we screw up for whatever reason and we want to make it right. Sometimes it's not us, but the insurance company moving so slowly, and you can't leave it up to the patient to fight it."

As director, she usually fields the toughest patient complaints, Saber says, often pulling cases from the collection agency or getting bills removed from credit reports.

"I never realized customer service was so wonderful," she adds. "I can't tell you the wonderful thank-yous I get. It just feels good to help somebody, clean up something, and then look at what we could do better to keep that from happening again."

All of the department's new employees go through a class based on the tenets of the best-selling book *Who Moved My Cheese*, Saber notes. "If you stay stagnant, the cheese disappears. We should be looking out for change coming, taking the initiative. We talk about it all the time. What are we going to do to make this happen?"

"We need to run ourselves out of business," she adds. "That would be the perfect world, but wouldn't it be nice if we can at least improve the things we can control in our own facility?"

One of the toughest things about the job initially, she notes, was the high turnover rate in her department. Although her first reaction was, "No, that's not going to happen," Saber says, she

HIPAA security rule now in its final form

Signature standard not included

Final security standards under the Health Insurance Portability and Accountability Act (HIPAA) for protecting patient health information when it is maintained or transmitted electronically have been adopted by the Department of Health and Human Services (HHS).

All "covered entities," which include health care providers, health plans, and health care clearinghouses, must comply with the rule, which was published Feb. 20 in the *Federal Register*. It includes the following provisions:

- All work force members, including management, must receive security awareness training.
- Organizations must conduct risk analyses to determine information security risks and vulnerabilities.
- Organizations must establish policies and procedures that allow access to electronic protected health information (PHI) on a need-to-know basis.
- Organizations must implement audit controls that record and examine who has logged into information systems that contain PHI.
- Organizations must limit physical access to facilities that contain electronic PHI.
- Organizations must establish and enforce sanctions against members of the work force who don't follow information security policies and procedures.

The electronic signature standard, a component of the proposed rule, was removed from the final version, which was published in the Feb. 20, 2003, *Federal Register.* HHS has said it will publish that standard in a separate final rule, but did not say when.

Some security experts have said the rule, while well integrated with the HIPAA privacy rule, lacks specific guidance in some critical areas, such as the requirement that encryption be used "only when deemed appropriate."

John Christiansen, JD, an attorney with Preston Gates in Seattle, has said the HHS accomplished one of its goals, which was to integrate the security rule with the privacy rule. He said many redundancies had been eliminated, in addition to some unclear concepts and rules.

For example, the chain of trust agreement, a document that would require business partners to protect electronic PHI received from covered entities, was eliminated. Covered entities are required to accomplish this through business associate agreements, which are required under the privacy rule.

HHS writes in the rule's preamble that the regulations are consistent with "generally accepted security principles."

The regulations will become enforceable for most covered entities, including hospitals, on April 21, 2005. Small health plans will have an additional year to comply. To view the final rule, go to www.access.gpo.gov. ■

came to realize it simply comes with the territory.

"The staff answer the phone all day long, mostly calls from angry patients," Saber says. "Right or wrong, they eventually get tired of that." Now, she says, what she promotes with her staff is, 'If I taught you something and you move on to another department, that's OK. It's the nature of the beast."

There is an ongoing exchange between Saber and her boss, she says, that illustrates her own frame of mind. "Every Friday, I meet with her one on one and I always end by saying, 'I love my job. You don't know how much I mean it. It's so rewarding and satisfying.'"

Now her boss, the chief operations officer for one of HCA's central business offices, will laughingly ask her if she still loves her job. "It's like a joke, but it's not," she says. ■

EMTALA issues involved in smallpox vaccinations

ED must treat those with reactions

Whether or not your hospital staff decide to participate in a voluntary smallpox vaccination program, there are Emergency Medical Treatment and Labor Act (EMTALA) issues involved by virtue of the fact that anyone is giving them, says **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

The limited number of vaccinations given so far has yet to produce major problems, notes Frew, a web site publisher (www.medlaw.com)

and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison. But he says it is the minor problems that are likely to get providers into trouble with EMTALA regulations.

"Put simply, some people will have reactions that may range from minor itching to more severe reactions," he says. "If they come to your emergency department [ED], you are obligated to treat them. You may not simply refer them to the health department or to the military or whoever gave the vaccination."

As with other ED presentations, the patient must receive proper triage, medical screening examination and care, Frew says. "Remember, there are some very serious complications potentially involved, and remember that it is possible for nonvaccinated family members and co-workers to have been contaminated by a vaccinated person who has failed to maintain the seal over the site."

"Have a plan on how you will handle it," he advises providers. "But you do have to handle it."

In other vaccine-related news, the Centers for Disease Control and Prevention (CDC) has released a Hospital Smallpox Vaccination Monitoring System intended to help providers track workers who receive the vaccine.

The web-based application is a component of the CDC smallpox vaccination program being offered as a free service to hospitals. It is designed to capture data such as symptoms reported by vaccine recipients, fitness for duty and workdays lost, and to produce summary and overview reports of the hospital's experience.

More information, including how to enroll in the voluntary program, is available at www.bt.cdc.gov/agent/smallpox/vaccination/hsvms. ■

Try to avoid sensitive material in your e-mail

Simple guidelines protect patients and staff

The SCPIE Companies, an insurer in Los Angeles, recently offered its own advice on reducing the risk of e-mail communication in health care. In addition to endorsing the eRisk guidelines, SCPIE says health care providers must be careful about when they choose to use e-mail.

The insurer says appropriate uses for e-mail include scheduling appointments, releasing records such as test results, providing follow-up instructions, explaining general medical information, answering billing questions, sending account reminders, and refilling prescriptions.

However, SCPIE cautions that requests for new prescriptions should not be handled through e-mail. Despite the convenience of e-mail, the patient should be examined in person to assess the medical necessity of any new prescription. Physicians also may consider prohibiting e-mail discussion of HIV test results, mental illness, alcohol or drug addiction, and workers' compensation claims as well. SCPIE recommends that, at the very least, patients should be required to type "SENSITIVE" in the subject line of all e-mail pertaining to these issues. The insurer also advises physicians not to use e-mail for answering clinical questions regarding a condition for which the patient has not been seen in the past six months.

When a physician and patient want to use e-mail, the physician should "discuss the process with the patient and ask him or her to read and sign an on-line communications informed consent form. This form may cover a variety of issues, including instructions for using on-line communications, good communication etiquette, charges for using on-line communications, conditions of using on-line communications, access to on-line communications, risks of using on-line communications and, finally, the patient's signature of acknowledgment and agreement. This information should become part of the legal documentation and medical record," it adds.

SCPIE also suggests that health care providers provide patients with a wallet-sized summary of the contract's highlights. It could be a special laminated card, a sticker affixed to the doctor's business card, or the information could be incorporated into the design of the business card. This is what the insurer recommends you put on the card:

- E-mail is not for emergencies! E-mail is not appropriate for urgent or emergency situations.
- Be concise. Come in for an appointment if the issue is too complex or sensitive to discuss via e-mail.
- Key in the topic (e.g., medical question, prescription renewal, appointment request) in the subject line.
- All e-mail will be filed in your record.
- Office staff may receive and read your messages.

SCPIE's e-mail advice can be found on-line at www.scpie.com. The American Medical Association (AMA) also has published guidelines for using e-mail. They can be found at www.ama-assn.org/

ama/pub/category/2386.html. These are some points found in the AMA guidelines:

- As part of the informed consent process for establishing e-mail usage, tell patients who besides you processes messages during usual business hours, and who processes them when you are out sick or on vacation.
- Maintain a patient e-mail mailing list, but do not send group e-mails in which recipients' names and/or e-mail addresses are visible.
- As with phone consultations, if the issue is too complex to discuss via e-mail, ask the patient to schedule an office visit.
- Set up an automatic reply to acknowledge receipt of patients' e-mail messages.
- When you answer patients' e-mail, ask them to acknowledge receiving and reading it.
- At the end of all e-mail messages, insert your "electronic signature," a pre-formatted standard block of text that contains your full name and contact information, as well as reminders about security and the importance of alternative forms of communication for emergencies. SCPIE offers this example of an appropriate electronic signature:

John Smith, MD
Dermatology
10 Main St.
Los Angeles, CA 90067
Phone: (310) 555-1212
Fax: (310) 555-4321
E-mail: jsmithmd@doctor.com

- Call the office if the matter is urgent.
- Call 911 in an emergency or go to the ER!
- Please follow security guidelines. ■

NAHAM conference scheduled May 3-6

The National Association of Healthcare Access Management (NAHAM) will hold its annual conference and exposition, "Expedition to Excellence," May 3-6 at the Hilton Cincinnati Netherland Plaza Hotel.

Workshops will cover such topics as "Best Practices for Patient Flow," "The Ups and Downs of Today's Revenue Cycle," and "The ABCs of ABNs." Keynote speakers include Michael T. Myers Jr., principal, MDXcel Consulting in Boston; Joseph L. Cappiello, vice president of accreditation field operations at the Joint Commission on Accreditation of Healthcare Organizations; and Kelli Vria, a humorist who will look at ways to handle stress in the workplace.

For more information, call the NAHAM office at (202) 367-1125 or go to www.naham.org. ■

AHRQ launches web site to aid in quality measure

The Agency for Healthcare Research and Quality (AHRQ) has launched a web-based National Quality Measures Clearinghouse (NQMC) designed to be a one-stop shop for hospitals, physicians, health plans and others interested in quality measures.

It contains evidence-based quality measures and measure sets available to evaluate and improve the quality of health care. The clearinghouse should be helpful as hospitals work to identify scientifically valid quality measures for hospitals as part of the National Hospital Quality Information Initiative, according to Nancy Foster, the American Hospital Association's senior associate director for health policy.

The initiative will start with 10 common measures approved by the Centers for Medicare & Medicaid Services; the Joint Commission on Accreditation of Healthcare Organizations; and the National Quality Forum.

Each domain of measurement in NQMC — access, outcome, patient experience, and process — offers a different insight into health care quality, according to information on the site. An access measure, for example, assesses the patient's attainment of timely and appropriate health care, while a patient experience measure aggregates reports of patients about their observations of and participation in health care.

COMING IN FUTURE MONTHS

- Revamping outpatient registration
- More on interdepartmental collaboration
- Life after HIPAA's privacy rule
- Is reimbursement on the way for illegal alien care?
- Tips on handling ABNs

The AHRQ clearinghouse is at www.qualitymeasures.ahrq.gov. ■

Bill to help hospitals fund immigrant care

In what is likely to be welcome news for hospitals burdened with the cost of caring for undocumented aliens, federal legislation has been introduced that would reimburse providers for the cost of emergency care for these individuals.

A bill introduced by Sen. Jon Kyl (R-AZ), and a companion bill introduced by Rep. Jim Kolbe (R-AZ) would reimburse hospitals $1.45 billion annually for the costs of adhering to the provisions of the Emergency Medical Treatment and Labor Act.

A coalition of health care providers in Arizona, California, New Mexico, and Texas worked with lawmakers on the legislation, according to a spokesperson for the Arizona Hospital and Healthcare Association (AzHHA).

"We are grateful to Arizona's congressional delegation for acknowledging that this federal mandate should be backed up with federal funds," said AzHHA president and CEO **John Rivers**. ■

Bush signs funding bill giving more to hospitals

More than $800 million in increased spending for hospitals is included in the omnibus spending bill signed in late February by President Bush.

The legislation includes a $300 million increase from April 1 through Sept. 20 in Medicare payments for rural and "other urban" hospitals through equalization of the standardized rate. It also provides $518 million in bioterrorism preparedness funding for hospitals, $15 million in new funding for the Nurse Reinvestment Act, and $28 million in education incentives for medical schools to incorporate bioterrorism-related information in their curriculums. ■