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IN THIS ISSUE

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Cancel the triennial 'stage play'; JCAHO has a new survey process

Get ready for everyday compliance, surprise visits, JCAHO VP says

Ever reflected on the absurdity of gearing up every three years to face the JCAHO surveyor — piles of policies in hand and brass freshly polished — only to heave a sigh of relief and go back to business as usual the next day?

The Oakbrook Terrace, IL-based Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) has a program for you, suggests **Joe Cappiello**, JCAHO's vice president for accreditation field operations.

Shared Visions, New Pathways, the new accreditation model — effective January 2004, with 2003 as operation development year — is designed to move the process from a commodity to a value-added product, Cappiello says. "We will ask the organizations we accredit to constantly look at their systems and processes and have continuous quality improvement, to improve on what they do best."

Additionally, in a recent decision that affects all accreditation programs beginning in 2006, the JCAHO board of commissioners has approved the initiation of fully unannounced surveys beginning in 2006, he says. That move likely will affect some aspects of the Shared Visions, New Pathways process, Cappiello adds, and those details currently are being worked out.

In the years since the initial Medicare legislation was signed in 1964 and being accredited by the Joint Commission was deemed to satisfy a hospital's Conditions of Participation in the program, he points out, there has been "a lot of misdirected effort to come into compliance."

"Many [providers] have decided they just need to do whatever it takes to be accredited so they are entitled to reimbursement under Medicare," Cappiello says. "It's not unusual for hospitals to ramp up the year before a survey, make sure their policies are nice and neat, and direct resources away from process improvement and direct care. A lot of that is nothing more than a stage play."

Shared Visions, New Pathways is designed to put the focus back where

it belongs, he says, on helping health care organizations "identify objectively the means and methods to improve care and give [them] an objective assessment of what their vulnerabilities in providing safe, quality care might be."

Under the new model, access services may find itself a more integral part of the survey process, he notes, due in large part to the "tracer methodology" that will be employed. Simply put, Cappiello says, "there is a realization that every patient who is admitted to the hospital comes into contact with every standard of the Joint Commission."

By following the natural course of patient care, which generally begins in admitting or the emergency department, the surveyor can get a very good view of how the health care delivery system is aligned to meet a specific patient's needs at a specific time, he adds.

Here are some components of the new accreditation model:

• **An 18-month mark event**

"Think of the date of the last survey and the three-year interval before the next one," Cappiello says. "About 15 months after that first survey, we will send out electronically a self-assessment tool called the Periodic Performance Review [PPR]. [Providers] will be asked to go through each of the standards and honestly assess themselves and tell us where they have failed to achieve full compliance with the standards.

"The idea is that if [hospitals] do a rigorous and thorough self-assessment and outline for the Joint Commission — what they plan to do to come into compliance and how they will measure the fact that they are now in compliance — there will be no penalty for that admission, and it won't change their accreditation status."

Hospitals will have until the 18th month to complete and submit that self-assessment, Cappiello adds.

• **Phone call with Standards Interpretation Group**

Before submission, he says, hospitals will schedule a telephone call with the JCAHO's Standard Interpretations Group to go over such questions as, "Have I scored this correctly?" or "What about this special situation?"

"[JCAHO] will go through and answer the questions so [the hospital] can fill that out as accurately and honestly as possible," Cappiello says. "We expect when we arrive 18 months later that they have done what they expected to do. We will spend 40 minutes to an hour looking at corrective action plans and make sure they've done what they said they would do."

If surveyors find that such action hasn't been taken and that the hospital is not in compliance with the standards, he adds, it will be scored in much the same way as with the current process.

• **Priority focus process**

The JCAHO's on-site survey process will be changed under the new model, Cappiello says. "We are going to have some tools that will potentially identify some critical issues for that medical center. There is a list of 14 critical focus areas, including communication, patient safety, and other things."

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Editorial Questions

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Such data as the organization's last survey result, any complaints made about them to JCAHO, and any sentinel events, such as a patient suicide or a wrong-site surgery, will be put into an algorithm, he explains. "We have designed a way for that to give us some information to better focus our survey activities."

"This priority focus process [PFP] may say that the cardiology unit, at a particular hospital for example, should be one of the spots to focus our activity because of high volume, a sentinel event, or something else," Cappiello says.

• **Tracer methodology**

Continuing the above example, surveyors are directed to the cardiology unit by PFP as part of something called tracer methodology, he says. "[The surveyor] would pick a chart out of the rack and review that chart on site to understand the entry point of the patient into the health care system, take some notes, and then trace the movement of the patient through the hospital."

Learning, for example, that a patient who speaks only Spanish was in Day 4 of a stay on the unit, had been driven to the hospital by her son, and was admitted through the emergency department after complaining of chest pain, a surveyor might ask the following questions of the registrar who admitted her.

"How did you ask whether the patient had advance directives? What are the procedures for dealing with patients who have a language problem? How did you get the consent to do the cardiology procedure? How did the transfer to radiology take place? How did the information about her move from this unit to that unit?"

By looking at the tracer, Cappiello says, surveyors can see compliance with the standards as care delivered, rather than saying, for example, "I want to see your policy on dealing with patients who don't speak English."

"It's inductive rather than deductive," he adds. For the average hospital survey, which is three surveyors for three days at a community-sized hospital, according to Cappiello, about 12 tracers will be done.

This following of charts through the health care delivery system, he explains, means there will be "a much higher engagement of access services staff than we have ever had before. We will talk about what they are responsible for and how to ensure they are doing the things they need to do. It's a conversation, not an inquisition, and there is no pat, right answer."

In the past, Cappiello notes, JCAHO would develop a series of probe questions to gain insight on how hospitals complied with its standards. "By the time we ask them at about the third hospital, they are all over the Internet," he says wryly. "Then it's about [hospitals] constructing the right answer, putting information on the back of ID badges and saying, 'If the Joint Commission asks this question, this is the answer.'"

"Think about the wasted effort in doing that," Cappiello adds, "when they could be spending time in more meaningful activities."

Although, during the survey, hospitals are required to demonstrate only that they've been in compliance for the past year, he points out, "We require hospitals to be in compliance with our standards every day of the year, every year."

Still being discussed, Cappiello notes, is how surveys will be scheduled so that they truly are unannounced, in accordance with the recent decision by the JCAHO board.

"In order to test this system," he adds, "we have accepted and will continue to accept on a voluntary basis, offers from organizations that wish to have their accreditation surveys unannounced in 2004 and 2005. We will probably do around 100 unannounced surveys [in 2004]."

It's likely that there will be some sort of yearly update of the PPR so that essentially it is current all the time," Cappiello explains. "Sometime the year a hospital is due, we'll show up. In practical terms, it could be a year before or a year after it's due. There will be no five-day notice. Literally, we will just arrive that morning."

Meanwhile, he says, the underlying purpose of Shared Visions, New Pathways remains.

"We really wanted to make [the accreditation process] something of value and to move the field toward continuous compliance," Cappiello notes, "not just for the burst of time when the Joint Commission is there, but all the time." ■

Without a JCAHO score, where are the distinctions?

'We want to stop the billboard war'

One of the key ways in which the Oakbrook Terrace, IL-based Joint Commission for the Accreditation of Healthcare Organizations' (JCAHO) new accreditation model "really blows up the old paradigm," says **Joe Cappiello**, vice

president for accreditation field operations, is that there is no score.

"We want to stop the billboard war in some cities, where one hospital puts up [on a sign] that it got a 94 and another hospital didn't," he adds. "The score is irrelevant."

Under the existing model, Cappiello notes, a Type 1 designation meant a hospital was "accredited with recommendations for improvement." After a series of events, he adds, the hospital was required to clear the items in question and then would be just accredited.

If the score was low enough, Cappiello says, it could lead to conditional accreditation or even preliminary denial of accreditation.

Beginning in 2004, a hospital surveyed by the Joint Commission won't receive a 92 or 86, he points out. "So how do we make a distinction between those that are doing great, those that need some help, and those that need a lot of help?"

The new process

"We are going to count the number of recommendations that are made on site, and then look at the average number of recommendations made the year before, in 2003, for all hospitals," he says. "Then we will go two standard deviations, and that will be the cut line for conditional accreditation. We will go three [deviations] from that and that will be preliminary denial of accreditation."

The process "will be driven by a statistically valid methodology that distinguishes one from another," Cappiello says. "The bottom line is that when the surveyor leaves, the facility will have the final report — not the final decision, but the final report."

The surveyed hospital may review that report, he continues, and respond that it does not believe the JCAHO's recommendation is valid. The facility might contend, for example, that the surveyor did not sample enough records, Cappiello says. To back up its contention, he adds, the hospital may submit evidence of standards compliance, which the JCAHO will review.

"It won't be a box full of forms or policies, but you must tell us why you believe you are in compliance, based on activity, not policy," Cappiello says. "For example, if the policy is that a history and physical must be performed, and [surveyors] found one of 10 charts in which this wasn't done, [the hospital] could say, 'You found the only chart out of thousands where that didn't occur.'"

The hospital then could show that it had sampled 250 charts and found only one case in which the procedure was not followed, he explains.

"We hold you accountable to your own policies," Cappiello says. If the hospital policy says certain things must be done to ensure a safe and thorough admission and review of the patient, "we're going to cite you" if those things are not done.

However, if an access employee fails to provide a patient with a privacy notice or ask about advance directives because that person was new to the job, or unnerved by the presence of the surveyor, he adds, the hospital could argue that point.

"[The hospital] might say to us, 'We can demonstrate that by pulling 25 other records from the same day in which all the requirements were met,'" Cappiello says. "We would take that into account and probably amend the recommendation."

When standards are found out of compliance, he notes, a hospital has one month "to fix them, to provide us a plan and evidence of how they will come into compliance, and how they will measure that they're in compliance."

After the hospital has provided measurable criteria to demonstrate its compliance, JCAHO will review the evidence, Cappiello says. "If we accept it, you are accredited. If you submit something and we don't believe it's on the mark, then you will be provisionally accredited."

This provisional status is subject to being publicly disclosed until JCAHO and the hospital agree on how the recommendations will be addressed, or if the two parties can't agree on a methodology, for the hospital to come into compliance, he adds. ■

Scanning system boosts registration efficiency

Document history available instantly

Registrars at the University Hospital of Arkansas in Little Rock are saving time and paper and creating more accessible records by scanning patients' insurance and health information into the computer, says **Mary Nellums**, CHAM, admissions manager.

"We're scanning the documents on the front end, [including] insurance cards, driver's licenses, and any kind of health information, such as letters saying a patient is approved for workers' compensation," she adds.

At present, scanning is being done in central registration, the emergency department (ED), and by two registrars in the preoperative area as a pilot project, she notes. "Outpatient and off-site clinics are not included at this point."

The pilot began in early 2003, Nellums says, with the purchase of small, individual scanners for each registrar's desk. Documents are scanned into different folders, depending on their use, she explains. "Everything that is an insurance document, such as a workers' comp letter or an out-of-network exception, goes into the insurance folder."

Before, registrars put hard copies of the various documents in patients' files, Nellums says, keeping them for six months to a year.

Under the new system, she points out, registrars immediately can see the history of a document. "After they scan in the driver's license the first time [a patient is registered]," Nellums says, "when the person comes in again, [the system] will show it has already been copied once."

Registrars still ask for the license, but then compare it with the existing file and scan again only if something has changed, she notes. "It's the same way with insurance cards. If there's a change, [the file] will pop up and show us the previous one."

Changes in insurance coverage thus are preserved in the file, in order of occurrence, Nellums explains.

"It's good for the billing department," she says. "[Billers] don't have to call us and say, 'Do you have a copy of the insurance card for this patient?' or 'Do you have a referral on this patient?' Everyone who has EPF [electronic patient file] access can go into the account and pull it up."

Nellums developed a process tree showing which documents should be scanned into which folder. As registrars are scanning a document, she says, they are given the opportunity to select a folder for that document. "They just click and it scans the document into the folder."

"For two or three weeks, people were putting [documents] in the wrong place or not understanding [the process], but now it's part of the routine," she adds. "It saves me a lot of time because they know [if something's wrong], I'm going to come back and ask them to fix it."

There previously had been one large scanner in the central registration area, Nellums notes. Besides not being convenient for ED staff or those in other areas to use, she adds, it often was not operational, so that hard copies were routinely made and filed.

And with the individual scanners, Nellums says, employees don't have to wait until they have documents from several patients and then make the trip to the scanner.

A few days before this year's April 14 deadline for implementation of the Health Insurance Portability and Accountability Act privacy standard, registrars began scanning privacy notices into the system after patients had signed them, Nellums notes.

There was some initial confusion with that process, she says, having to do with indicating the different ways of providing the notice. Registrars may enter "notice provided," "notice mailed," or "urgent situation," for example, to describe the interaction.

The majority of the time, Nellums explains, registrars use "NP," for "notice provided," meaning they gave the notice to the patient, who in turn signed it. "Urgent situation" was created, she adds, to be used when the patient has been in an accident or for some other reason is unable to acknowledge the notice.

"In the beginning, it was hard to choose which one," Nellums says, "and [registrars] would use 'US' with obstetrics patients."

ED registration revamped

In another innovation involving the ED, she notes, University Hospital instituted a new registration process in August 2003, with the dual aim of enhancing customer service and ensuring compliance with the Emergency Medical Treatment and Labor Act (EMTALA). **(For more on ED registration and EMTALA, see Access Feedback on p. 66.)**

In the past, Nellums explains, ED patients — except those who had chest pain or another life-threatening condition — came to the registration desk upon arrival, where an account was established and a full registration was done. Patients then were sent to triage, where a nurse evaluated them, she says.

Now all patients go first to the triage nurse, who does a quick registration, obtaining just name, date of birth, arrival date and time, Social Security number, race, sex, and chief complaint, Nellums says.

The quick registration sheet prints out in the registration area, she notes, saying, for example, "Patient has gone to Room 7." Registrars actually can see patients walk up for triage, as well, Nellums adds, and often are waiting at the printer so they can go immediately to do the registration.

"Our people go to the bedside and use the update function to fill in the additional registration information," she says.

Providing adequate registration training for the nurses is crucial to making the process work efficiently, Nellums advises. "I'm not sure our nurses received enough training to prevent [the issuing of] duplicate medical record numbers. We did a lot of cleanup on the back end."

"Nurses are geared more toward making sure the patients are taken care of than getting demographic information," she says. "At the beginning, they felt, 'We don't want to worry about that.'"

Now, she adds, the number of duplicate records has "finally slowed down. We're down to a couple of patients every other day for which we may find a duplicate."

Although instituting a quick registration process had been discussed several times in the past, Nellums says, it came to fruition with the arrival of a new ED manager. "It's a big change for the staff not to have the patient come to them, but the majority of them now are geared to do it. They realize it's more patient-friendly to go to the bedside."

Patients, in turn, "seem to feel they're being treated better having people come to them rather than sitting in front being asked a lot of questions," she notes. "What I've observed is that once they're in a bed and have had their blood pressure checked, [patients] are more prone to go ahead and give all the information more freely."

Once they're more at ease and feel they're being taken care of, Nellums adds, the patients aren't as likely to try to limit the conversation.

[Editor's note: Mary Nellums can be reached at (501) 686-6789 or by e-mail at Mary.C.Nellums@fcsmtp.uams.edu.] ■

ACCESS FEEDBACK

New discharge station aids ED copay collection

Full registration occurs after treatment

Cheryl Staske, MS, director, hospital registration centers, at Carle Foundation Hospital in Urbana, IL, has some feedback for access colleague **Kathy Pajor**, who seeks advice in the March issue of *Hospital Access Management* on how to increase point-of-service collections in the emergency department (ED) while strictly adhering to the provisions of the Emergency Medical Treatment and Labor Act (EMTALA).

Pajor, director of patient access services at St. Vincent's Medical Center in Bridgeport, CT, asks what plans are in place to allow successful copay collection, despite the fact that EMTALA prohibits access staff from delaying the medical screening examination to obtain authorization or collect money.

At Carle Foundation Hospital, Staske says, her department uses a two-step procedure to increase collections. **(See process flowchart, p. 67.)** "Our process in the ED," she explains, "is that patients are seen in triage first. When they are finished, they come to [access staff] and complete a half-sheet form, five or six key pieces of information — name, address, date of birth, medical record number at Carle Foundation Hospital."

After that, Staske continues, patients go back to the treatment room, where they receive the medical screening exam, and whatever treatment is necessary. "When they are finished being treated, they are directed or escorted to the registration discharge station."

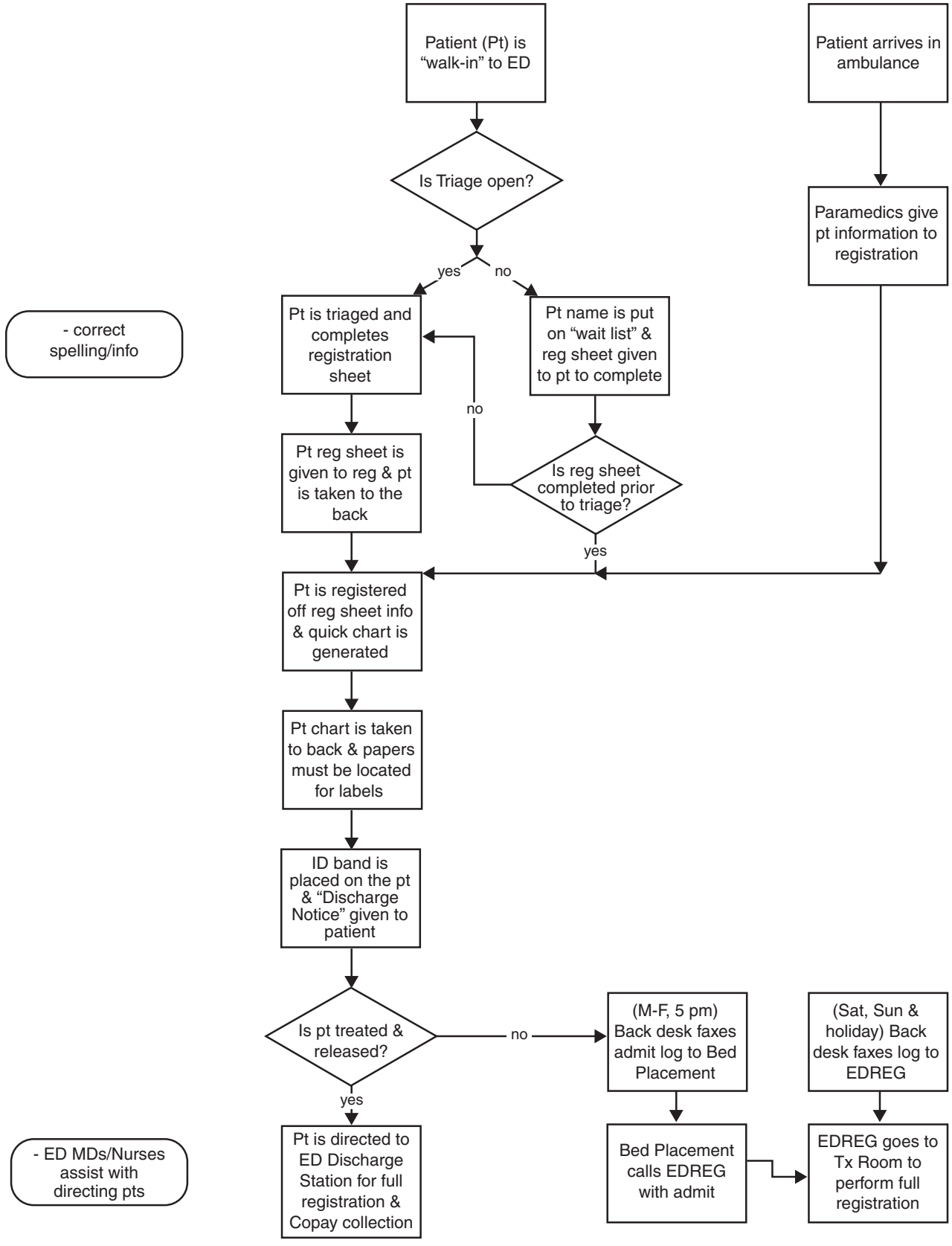
At that point, she says, access employees do a complete registration, verifying insurance, getting consent forms signed and completing a Medicare Secondary Payer form if necessary.

"Through an on-line eligibility system called Nebo, we see if we can verify the [amount of] the copay," Staske says. "Some of the biggest struggles are that ED patients often don't carry an insurance card, or they have insurance that is not part of the on-line eligibility system."

The Nebo system covers some eight third-party payers, she says, including Aetna, Cigna, Humana, Blue Cross Blue Shield, and the Illinois Department of Public Aid, among others. They represent about 80% of the insurers with which

(Continued on page 68)

EDREG Discharge Station



Source: Carle Foundation Hospital, Urbana, IL.

the hospital does business, Staske adds.

However, she notes, "many [third-party payers] do not list the copay. Some just list the percentage of charges, but because we don't know what the charges will be at that point, so we can't calculate [the copay]."

The hospital is considering charging a flat rate in such cases, Staske says, but the concern is that this will create additional work for billers on the back end. "We might need to have a conversation with them."

Because the full registration is done after treatment is completed, she says, the challenge is making sure patients make that last stop at the discharge station. "There is a percentage of patients who bypass us."

Since the discharge station was instituted in December 2002, Staske notes, that percentage has dropped from 35% to about 22%, thanks primarily to the cooperation of clinical staff. "The nurses and physicians help us by directing patients [to the discharge station]."

ED physicians not always cooperative

Mary Nellums, CHAM, admissions manager at the University Hospital of Arkansas in Little Rock, would like some suggestions on how to gain the cooperation of ED physicians in handling nonurgent Medicaid patients.

"When Medicaid patients come to the ED but are not really urgent cases, we are trying to get the physicians to send them to their primary care physician (PCP)," Nellums says. "Sometimes these patients use the ED as a clinic."

Medicaid requires a referral from a PCP to cover the ED visit, she notes. "We'll try to call while the patient is here [at the ED], but the PCP won't give a referral." That leads to Medicaid refusing to cover the visit, Nellums adds.

"The ED physicians are not educated as far as the importance of getting that referral and the impact on the back end," she says. "[The hospital is] denied payment because there was no referral and the patient just had a headache."

Although the medical director of the ED understands and supports the effort to get proper referrals, at first, he was getting conflicting reports on the situation, Nellums adds. "We were telling him what was happening, and the physicians were saying that they were cooperating."

Access staff began keeping records, she says. "We're now providing reports of Medicaid patients who showed up and for whom we didn't get a referral. We show when we gave the physician notice to call and he wouldn't."

Nellums welcomes ideas from access colleagues who have been effective in getting physicians to work with access staff to obtain Medicaid referrals.

[Editor's note: If you would like feedback on an issue of interest to access professionals, please contact Lila Moore at (520) 299-8730 or by e-mail at lila moore@mindspring.com.] ■

Keep EMTALA in mind while taking SARS action

Expert addresses prescreening issue

Don't let concerns about severe acute respiratory syndrome (SARS) prompt measures that will put your hospital at risk for violations of the Emergency Medical Treatment and Labor Act (EMTALA), warns **Stephen Frew**, JD, a web site publisher and longtime specialist in EMTALA compliance based in Loves Park, IL.

In a recent article on his web site, www.medlaw.com, Frew says he was asked by a nursing publication to comment on a story about how to prescreen patients at the curb to ensure they were not SARS patients.

"Come on, folks," was his response. "How many hundreds of EMTALA violations are you going to induce without the slightest statistical chance of successful interdiction of the infinitesimally small infected population?"

"SARS is a droplet infection according to the current public health statements," says Frew. "We have known how to reduce exposure to droplet infections for more than a century."

Hospitals already are required to have "universal precautions" for other types of diseases transmitted by droplet and body fluids, he points out. "The *only* chance of pre-emption is to use them for this situation as well."

"The president has issued an executive order adding SARS to the permissible quarantine list," Frew adds, "but that does not indicate that EMTALA is repealed."

Handling 'informed refusals'

In another piece of EMTALA advice, Frew poses this question to hospitals: "When someone

walks out of your ED, refuses a transfer, or refuses an ambulance, how are you documenting that?"

Many facilities use their standard Against Medical Advice (AMA) form, but that usually does not meet EMTALA standards, he says. That's because the EMTALA requirement for a refusal form (Informed Consent To Refuse) requires a lot more documentation than the typical AMA form, Frew adds.

"Specifically, the form must provide *individual* risks for the patient for the element of care that was refused," he explains. "Most AMA forms just have some lame language like, 'The risks of refusing care have been explained to me.' Sorry, that's not good enough."

Similarly, he says, putting "risks and benefits discussed with patient and patient voices understanding" also is not good enough. "You have to list exactly what you 'informed' the patient about the risks of refusal, so that when [the patient] signs the form, you have evidence that it is an informed refusal."

If the particular issue is not listed, Frew says, the patient is not informed.

"Another nasty part of the AMA," he adds, is that many insurance companies shut off coverage for everything associated with the visit if there is an AMA.

"Don't shoot yourself in the foot," Frew cautions. "Get refusals, not AMAs. Use AMAs only for serious issues arising after a full exam — the person who desperately needs blood but refuses due to religion. In those cases, get both."

(A sample refusal form is available on Frew's web site at www.medlaw.com/forms.htm.)

Disaster plans addressed

Frew also reminds hospital EDs that temporary privileges granted to volunteer physicians, nurses, and other licensed health care professionals responding to a disaster must be referenced in the facility's emergency preparedness plans and stated fully in medical staff bylaws.

"This is different from allowing emergency privileges to a staff member to provide services in a lifesaving situation," he points out. "It is also different than temporary privileges to cover a staffing gap or while full credentialing occurs.

It runs contrary to existing Centers for Medicare & Medicaid Services (CMS) practice to cite a hospital that is on disaster status, Frew notes. Likewise, CMS personnel indicate that they are not likely to cite for someone exceeding privileges to provide a lifesaving intervention, he adds.

"Temporary staff, however, have caused EMTALA violations in EDs by not being familiar with policies and procedures, not knowing the resources available, not being responsive to regular staff input, and not having established loyalties to the institution," Frew says.

CMS frequently looks closely at the credentials files of medical and nursing staff in the ED to make sure they meet state and institutional credentials standards, he says, adding that failure to have all required certifications, licenses, and credentials in the file have been frequent causes for citations.

"Make certain that your credentials files are current on all of your regular personnel, verify that all policies and procedures criteria are met for all regular personnel, and be certain that all personnel are regularly retrained on EMTALA," Frew advises.

Temporary and float personnel must meet the same standards as regularly assigned personnel to withstand a CMS audit and to meet a hospital's own policy standards, he adds.

"While some hospitals may find it difficult to fully staff with regular, experienced nurses and physicians," Frew points out, "the risk of violation and malpractice goes up dramatically when temporary personnel, infrequently involved staff, or float or agency personnel are used in the ED." ■

New privacy issue not about HIPAA

CA law affects Blue Cross policies

There's a new patient confidentiality development access personnel should know about, and it has nothing to do with the Health Insurance Portability and Accountability Act privacy standard.

A California law that took effect July 1, 2002, and is being implemented in phases puts measures in place to protect the integrity of the Social Security number (SSN), among them the prohibition of using the number as an insurance subscriber identifier, points out **Liz Kehrer**, CHAM, system administrator for patient access

at Centegra Health System in McHenry, IL.

In anticipation of a Jan. 1, 2004, deadline for entities providing or administering health care or insurance, Blue Cross Blue Shield (BCBS) is issuing insurance cards for new accounts/policies in 2003 in which a generic number, not the subscriber's SSN, is used as an individual identifier, Kehrer explains. Beginning July 1, 2005, those entities must comply with all requirements of the law for all individual and group policyholders in existence prior to Jan. 1, 2004.

"Access managers need to start looking at having registrars really double-check those Blue Cross cards and the accuracy of that subscriber ID number," she cautions. "We're already seeing instances in which the change has been made."

What can happen, Kehrer notes, is that with all other insurance information — group number, mailing address, etc. — the same as on a patient's last visit, the registrar may neglect to make note of the different subscriber identifier, thus resulting in inaccurate claims.

Her research on the subject, she adds, suggests that it is only a matter of time before similar laws protecting the SSN are enacted in other states.

Under the California law, which is found in Civil Code Sections 1798.85-1798.86 and 1786.60, companies *may not* do any of the following:

- post or publicly display SSNs;
- print SSNs on identification cards or badges;
- require people to transmit an SSN over the Internet unless the connection is secure or the number is encrypted;
- require people to log onto a web site using an SSN without a password;
- print SSNs on anything mailed to a customer unless required by law or the document is a form or application.

Providing background on the unique status of the SSN as a privacy risk, the Office of Privacy Protection in the California Department of Consumer Affairs explains on its web site that the SSN was created by the federal government in 1936 to track workers' earnings and eligibility for retirement benefits.

Now, however, the SSN is used in both the public and private sectors for myriad purposes totally unrelated to that original purpose, the site points out. That broad use and public exposure of SSNs, it adds, has been a major contributor to the tremendous growth in recent years of identify theft and other forms of credit fraud.

For more information, go to www.cdc.gov/nchs/. ■

Consent form, patient care subject of new study

Getting advanced consent for eight commonly performed procedures when patients were admitted to a hospital intensive care unit (ICU) significantly increased the frequency with which informed consent was obtained, without compromising the consenter's comprehension of the process, according to a recent study.

Investigators reasoned that providing patients and their proxies with information about procedures at admission and obtaining consent for some of the procedures that might be performed would increase their understanding of those potential elements of care. Doing so also would allow a greater number of proxies to participate in important decisions regarding care, they theorized.

In the study, reported in the April 16 issue of the *Journal of the American Medical Association*, a university hospital gave patients and/or proxies a single consent form for eight common ICU procedures upon admission to the ICU, introducing physicians and nurses to the form during orientation to the unit. Handouts describing each procedure also were available in the ICU waiting area.

Under the new process, 90% of procedures were performed with consent, compared with 53% before, and the consenter's comprehension of the indications and risks of the procedures remained high. ▼

Interim rule issued for HIPAA penalties

An interim rule establishing procedures for imposing civil monetary penalties on entities that violate standards adopted under the Health Insurance Portability and Accountability Act's (HIPAA) administrative simplification provisions has been issued by the Department of Health and Human Services.

The rule, published in the April 17 issue of the *Federal Register*, is the first installment of the department's enforcement rule for the provisions. It informs regulated entities of the agency's approach to enforcement. The rule was effective May 19, 2003, and expires on Sept. 16, 2004, when the final rule will be published.

Other upcoming HIPAA deadlines are as follows: Oct. 16, 2003 is the compliance date for electronic transactions and code sets. The National Employer Identifier was effective July 30, 2002, and covered entities must comply with the requirement by July 30, 2004. The Security Rule regulations will become enforceable April 21, 2005, for most covered entities, including hospitals. Small health plans will have an additional year to comply. ▼

Hospital mergers down, recent study shows

Hospital merger activity declined significantly in 2002, hitting its lowest level in 10 years, according to a recent report by Irving Levin Associates based in New Canaan, CT.

In 2002, 58 hospital mergers or acquisitions involving 101 hospitals were announced, down from 83 transactions involving 118 hospitals, Irving Levin said. One transaction, the purchase of Health Midwest by HCA, accounted for more than 30% of the total $3.5 billion in deals transacted in 2002, the publisher said.

The number of hospital transactions declined 30% in 2002 and has plunged by more than 70% since peaking in 1997. Much of the decline in activity over the past several years reflects the diminishing role of nonprofit hospital organizations as buyers, according to the report.

Five years ago, the buyer in 75% of the hospital transactions was a nonprofit, compared with just 25% in 2002, according to the *Health Care Acquisition Report*. ▼

Medical liability reform still needed, survey says

Legal reforms have slowed the growth of medical liability insurance premiums where they have been enacted, but federal reform still is needed, says a recent report in the on-line news service *AHA News Now.*

Medical liability expenses are twice as much for hospitals in what the American Medical Association has identified as "crisis states," according to a recent survey of 1,000 facilities by the American Hospital Association.

In these crisis states, the survey notes, medical liability costs are as much as $11,435 per staffed bed, compared with $4,228 in noncrisis states.

Commenting on the survey, **Gerry Miller**, president and CEO of Crozer-Keystone Health System in Springfield, PA, said, "Something is substantively wrong when a system like Crozer-Keystone spends more on insurance than on all the medications we buy for the patients we care for."

Jeff Curtis, president and CEO of H.S.C. Medical Center in Malvern, AR, said his hospital "had no choice but to discontinue delivering babies" because local physicians could not afford to pay their premiums. ▼

More help sought for rural hospitals

The Rural Community Hospital Assistance Act, introduced in late April by Sens. Ben Nelson (D-NE) and Sam Brownback (R-KS) could provide some relief for financially troubled rural hospitals.

The act enhances the Critical Access Hospital program, which provides special Medicare reimbursement for certain rural hospitals with 15 or fewer inpatient beds; helps rural hospitals with

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50 or fewer inpatient beds by allowing them to use cost-based reimbursement instead of the prospective payment system; ensures that these hospitals will receive 100% compensation for treating Medicare patients who fail to supply their copay; and provides additional funding for technology and infrastructure needs.

The bill is a companion measure to H.R. 937, introduced by Reps. Jerry Moran (R-KS) and Jim Turner (D-TX) in February.

The legislation is part of AHA's agenda of helping rural hospitals by establishing a more equitable Medicare area wage index and continuing better Medicare base payments for rural and other urban hospitals.

For more information, go to www.aha.org. ▼

LOS trending down, CDC survey explains

The average hospital stay was 4.9 days in 2001, the latest year for which data are available, according to a survey by the Centers for Disease Control and Prevention (CDC).

That figure, which is based on a survey of discharges for nonfederal short-stay hospitals in the United States, is the same as in 2000, but down from 7.8 days in 1970. The average length of stay as measured by the survey rarely changes dramatically year to year, but has been trending downward for all patients except children for the past three decades, CDC experts noted.

The most dramatic decrease in the length of stay has been for elderly patients, dropping from an average of 12.6 days in 1970 to 5.8 days in 2001. The average stay for children has held steady at around 4.5 days.

The rate of hospitalization for most conditions also has decreased over the past two decades. An exception is congestive heart failure, which has gradually increased by 62% for those 65 and older since 1980. CDC officials said the increase reflects the success in treating through drugs and surgery more acute forms of heart disease, such as heart attacks, thus extending the lives of many elderly people and making it more likely they will develop chronic heart problems.

For more on the CDC's 2001 National Hospital Discharge Survey, go to www.cdc.gov/nchs. ■