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Knowledge (of denials) is power; integrated database provides it

Tracking and teamwork make the difference at Brigham & Women's

If you think your hospital doesn't have a problem with denials and you aren't doing anything to track them, **Christine Collins**, CHAM, strongly suggests that you just don't know one way or the other.

The heart of successful denial management, emphasizes Collins, who is director of patient access for Boston's Brigham & Women's Hospital, is a denial database, which categorizes the bills that are denied and the reasons why.

With the challenges of clinical vs. administrative denials, observation vs. inpatient status denials, and complicated time-sensitive authorization processes, she adds, the cash flow can be difficult to follow.

To get a handle on what wasn't getting paid and why, the hospital formed an inpatient denial team — co-chaired by Collins and a physician — to oversee the process, with representation from patient access, billing, medical records, and care coordination. Boston-based Partners Healthcare system, of which Brigham & Women's Hospital is a member, awarded the team a 2001 Partners in Excellence Award for outstanding

Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) takes effect Nov. 10.

To provide you with critical information on the updated regulations from the Centers for Medicare & Medicaid Services, Thomson American Health Consultants offers **New EMTALA Regulations: Are They Too Good to be True?** — an audio conference on Tuesday, Oct. 21, from 2:30-3:30 p.m., EST.

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efforts in improving management of denials. Collins says the team continues to be recognized for its achievements.

Building a denial database was the first order of business, she says. An analyst in the patient access department provides upkeep of the database, while the following areas handle other functions:

- Care coordination — provides analysis of clinical/utilization review denials.
- Patient access — assesses authorization processes.
- Patient accounts — pursues final outcome.
- Medical records — handles documentation needs.
- Medical director — handles clinical appeals.

The process begins, she explains, when accounts receivable gets a denial and puts it into the database, assigning it to a person based on the kind of denial it is.

"What we do that's wonderful," Collins notes, "is assign denials so we can track them. If [a denial] comes to my office, but is clinical, I reassign it to a person who can handle it. If it's a precert or preauthorization [issue], it's assigned to my staff."

IT drives the process

"Most hospitals," she adds, "don't have the IT [information technology] to have this information at their fingertips — [information about] who's working what."

Pat O'Keefe, denial manager in patient access services, is in charge of handling all technical and administrative denials, Collins says, and at times works very closely with care coordination personnel. "In every area, care coordination has one or two people who own this [denial management] process."

O'Keefe says she consults with utilization review nurses to determine whether a patient has inpatient or observation status, which often is a point of contention with insurance companies responding to claims.

On a day-to-day basis, O'Keefe notes, she is responsible for researching any (technical and administrative) denials that are related to inpatient admission. "[That includes] writing the appeal and getting any kind of documentation I need to support our case."

"If we believe we followed the proper procedure, that means doing screen prints of notes saying who we spoke to [at the insurance company], what authorization number we got, and also getting any necessary medical documentation, and sending it off to the insurance company," she says.

Even in the case of technical or administrative denials, O'Keefe says, many insurance companies require that a patient's medical record accompany the appeal.

"I have a spreadsheet that I've developed," she adds, "and every time I send out an appeal, I enter it on the spreadsheet so I can keep a running total, including what the status is, if an appeal is still out."

Her practice always is to send appeals by certified mail, O'Keefe says. "It doesn't always

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Editorial Questions

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work, but it's much better than not having a receipt."

Timely payment, improved processes

Collins is reluctant to make before-and-after comparisons regarding dollars recouped by the denial management initiative. A reimbursement denial that's now quickly reversed via the new denial management process eventually might have been handled successfully through appeals, she points out.

"[In the past] if we had these denials and weren't tracking them but did a lot of legwork and eventually got paid anyway, it might have taken six months instead of six weeks," Collins says. "In the old days, and still at many hospitals, people in accounts receivable are constantly resubmitting bills."

The beauty of the tracking process, she adds, has been in the ability to notice trends, improve processes, and work with payers on better system-to-system communication.

"Data is so powerful," Collins notes. "Until you have that, you're looking at [denials] one by one. Once we track them, we have the documentation to support why we shouldn't have been denied. Settlements with payers can be made based on data. We maintain all the documentation on-line, and we follow up denied claims until resolution."

Within the database, there is the capacity for electronic communication to prompt steps in the appeal process, she says.

"If we notice that something is a trend and should not be a denial, we can include that in the next contract negotiation," Collins says. "For instance, most payers want you [in maternity cases] not only to authorize the mother, but also the infant. There are all sorts of issues with payers and newborns."

Problems lead to solutions

Examining individual problems can lead to long-term solutions in other areas. Some redundancies in the preauthorization process can be beneficial to the payer as well as the hospital, she points out. "They want to make their administrative burden smaller, too."

With one payer, O'Keefe notes, the hospital has been able to negotiate that authorization is not required for mother or baby if the baby is born at Brigham & Women's. "We still need [authorization] if the baby is born elsewhere and transferred here."

Having made this inroad with one insurance company, the hospital cites it as a precedent in talks with other payers, she adds. "The idea [behind eliminating the authorization requirement] is that the insurer knows the women are pregnant, and that they will be coming to the hospital — they may even be having their OB [obstetrics] visits here."

While in the past a payer might contend that the hospital never had made a preauthorization call on a particular case, the capacity for electronic communication puts the accountability on both sides, Collins points out.

"When we start to do an autopsy on denials, we say, 'Gee, their system has its own problems.' Sometimes what we have here is different from what they think. If you don't dot an 'I' on one system, the other system kicks [the bill] out."

With one insurance company, O'Keefe says, the hospital was having a difficult time with maternity admissions because the insurance company consistently said that the first day of the hospital stay was not approved.

"As we analyzed it, we saw that the women in those cases came in one day, were in labor and delivery, and then delivered the next day," she adds. "This insurance company had someone who — when we called to notify them of a delivery — was listing that day as the admission day."

When the insurance company was provided with data showing it was a payer problem, O'Keefe explains, it took responsibility and corrected the claims without making the hospital go through the appeals process.

That is significant, she says, because of the extraordinary length of time that process can take. "When we first started doing appeals, [the payers] had not had a lot of hospitals doing them," O'Keefe adds. "It would take five months or longer for them to acknowledge that we'd sent an appeal. Then they would send a letter saying we would be notified in 45 days."

Tracking denials prevents certain groups of patients from slipping through the cracks in the admitting/screening process, she notes. In the past, patients could be in and out of the ED in the middle of the night and even though there was a service that required a different authorization their names might not appear on the admitting list, O'Keefe explains.

Now, she says, those cases are tracked, billed in a timely manner, and there is no need to work

later to reverse a denial that might otherwise have occurred.

What Brigham & Women's system provides, Collins points out, "is more understanding so we can improve our process. Until you have a common, integrated database that is completely open, honest, and hospitalwide, you're not going to have that.

"It's the little things," she adds. "It's truly understanding the business and what the issues are, and [asking] how can we fix them."

[Editor's note: Chris Collins can be reached at (617) 732-7453 or cfcollins@partners.org. Pat O'Keefe can be reached at pokeefe@partners.org.] ■

CMS hopes final EMTALA rule will ease burden

New rule is both good and bad news

There is much to rejoice about in the final rule of the Emergency Medical Treatment and Active Labor Act (EMTALA), with many of the most vexing parts of the law either clarified or eliminated altogether, but there still is plenty to keep you busy. The new rule will lessen risk in some areas, but it also may increase liability from a longstanding problem — the difficulty of getting enough physicians to take call for EMTALA coverage.

The final rule is "good news, some more good news, and continued bad news," says **Mark Kadzielski**, JD, head of the West Coast health practice in the Los Angeles office of the law firm of Fulbright & Jaworksi and an expert on EMTALA. He says Centers for Medicare & Medicaid Services (CMS) administrator Tom Scully was on target when he announced the new rule by saying that it "carries out EMTALA in a common sense and effective way."

EMTALA applies to all hospitals that participate in the Medicare program and offer emergency services and covers all patients treated at those hospitals, not just those who receive Medicare benefits. Hospitals that violate EMTALA may have their Medicare participation terminated and may be subject to civil money penalties of up to $50,000 per violation. Individuals who have suffered personal harm and hospitals to which a patient has been improperly transferred and that have suffered financial loss as a result of the transfer also are provided a private right of action against hospitals that violate EMTALA.

One of the most difficult parts of EMTALA essentially was eliminated in the final rule, Kadzielski says. The "250-yard rule," which was prompted by an infamous case in which emergency department staff did not leave the hospital grounds to render aid to someone nearby, was made moot by new definitions outlining when EMTALA applies. Instead of the previous interpretation, which stated that the hospital was responsible for anyone who was within 250 yards of the hospital campus (and "campus" was defined broadly), the final rule now makes clear that EMTALA applies only in specific areas that meet one of three definitions. **(See new definitions and other specifics, p. 113.)**

In effect, CMS is stating that EMTALA applies only when people come to an area in which they could reasonably expect to receive emergency treatment, Kadzielski says. There no longer is any need to try to figure out where your campus begins and what falls within 250 yards.

EMTALA does not apply to inpatients

And to make things even better for hospitals, CMS declared that EMTALA does not apply to inpatients. That severely limits how much of a hospital's operations are subject to EMTALA.

"If I take my daughter to a doc-in-the-box affiliated with a hospital and they don't screen her properly, in the old days I could have sued for an EMTALA violation," he says. "Here the new rules say no, not unless it is specifically licensed as an emergency room, or held out to the public as a place that provides emergency care, or unless emergency cases made up a third of all cases for the prior year."

The bad news involves CMS's final word on the difficulty of getting doctors to take calls for EMTALA coverage, Kadzielski says. This has been a difficult part of complying with EMTALA for years, as hospitals find it difficult to keep enough physicians on call to ensure that an emergency patient can get a proper screening or treatment by a specialist. Hospitals, especially risk managers, had hoped the final rule would help them force doctors to take call, but that didn't happen.

"The government hasn't done anything to help hospitals get physicians to take call," he says. "They just said it's up to you. Work it out however you want to, but the hospital has to provide coverage."

Some finer points of the updated EMTALA

These highlights of the final EMTALA rule were summarized by the Centers for Medicare & Medicaid Services (CMS):

- The new rule changes the definition of emergency department to mean any department or facility of the hospital, whether situated on or off the main hospital campus, that: 1) is licensed by the state as an emergency room or emergency department; 2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or 3) during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.
- CMS clarified the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff on-call lists. Under the revised regulations, hospitals will have discretion to develop their on-call lists in a way that best meets the needs of their communities. In keeping with traditional practices of "community call," CMS says physicians will be permitted to be on call simultaneously at more than one hospital, and to schedule elective surgery or other medical procedures during on-call times.
- The rule confirms that hospital-owned ambulances may comply with citywide and local community protocols for responding to medical emergencies and thus be used more efficiently for the benefit of their communities.
- Hospital departments that are off-campus now can now provide the most effective way of caring for emergency patients without requiring that the patient be moved to the main campus, when this would not be best for the patient.
- The final rule clarifies that EMTALA does not apply to individuals who come to off-campus outpatient clinics that do not routinely provide emergency services or to those who have begun to receive scheduled, nonemergency outpatient services at the main campus — for example, routine laboratory tests. Other regulations and state licensing laws already cover the hospital's obligations to patients in such circumstances.
- The rule clarifies that EMTALA does not apply after a patient has been seen, screened, and admitted for inpatient hospital services, unless the admission is made in bad faith to avoid the EMTALA requirements. This provision was adopted to conform to the decisions of five circuits of the United States Courts of Appeals. ■

CMS decided to stay out of the fight and simply give doctors and hospitals maximum flexibility to work out their disagreement, Kadzielski says.

"The final rule also allows doctors to be on call at more than one hospital and to do elective surgery while on call, so they're effectively not available," he says. "It makes it easier for doctors to take call, but it doesn't give any hints to the hospital as to how to provide coverage."

One part of the rule related to physician coverage may seem like good news, but Kadzielski cautions that there is a hidden risk. The rule clarifies that it now perfectly legitimate for a hospital, for instance, to have orthopedic coverage on Monday, Wednesday, and Friday, and to have neurosurgery coverage only on Thursday. That is often the best a hospital can manage when specialist physicians are too few or just won't take calls.

So that's good news, right? Not entirely, Kadzielski say. The final rule will give you a defense if you were unable to provide enough physician coverage, but it's not an ironclad defense.

"If I'm a plaintiff I'm going to sue and argue that the way you limited this call is not rational, not appropriate and is a violation of EMTALA," he says. "The hospital will argue that the final rule says it's up to our discretion and that was our decision. But the patient will argue you abused your discretion, knew that was inadequate call coverage, and therefore you should have liability. It's going to get crazy like that."

Kadzielski says "not only did they make the on-call situation worse by not providing any guidance, they made it worse by leaving it all up to the hospital to decide. That means that when someone disagrees with your decisions about on-call coverage, it's all in your lap."

Could end up with many more transfers

With that kind of hands-off approach from CMS, the nationwide on-call crisis is not likely to improve any time soon. Kadzielski says the final rule is likely to exacerbate the situation and lead to more patient transfers when the emergency department can't find a specialist. **George Molzen**, MD, president of the American College of Emergency Physicians in Irving, TX, agrees and conjures up images of patients being driven all over town in search of the one hospital that has the right specialist on call.

"Hospitals also can allow specialists to opt out of being on call to the emergency department." Molzen notes. "This means that patients in need of specialty care may need to be transferred to other hospitals. But the question is where? We already have a shortage of on-call specialists because of the medical liability crisis. This rule could exacerbate an already difficult situation."

And if your hospital is the one that managed to keep specialists on call, guess what. All those transfers will be coming to your emergency department.

The new rule potentially could leave only a few hospitals left with medical specialists, which means those hospitals may be flooded with emergency patients, Molzen says. It could result in conflicts between hospitals over who will provide specialty care and result in delayed care or more transfers of patients, exacerbating the ambulance diversion problem.

Don't think EMTALA is toothless now

Aside from the on-call issue, the EMTALA final rule is largely good news for health care providers. But according to one CMS official, don't assume the government is going soft. CMS still has every intention of enforcing EMTALA diligently, says **Charlotte Yeh**, MD, FACEP, CMS regional administrator in Boston.

"No one should look at this as a wholesale change or weakening of EMTALA," she says. "It's just really a much better balance and assurance that patients will get the necessary care without being overly burdensome to hospitals. This makes it more manageable."

CMS intended to clarify much of the EMTALA rule that had made compliance difficult, and to codify some court rulings over the past years that affected how the law was interpreted and enforced. In particular, she says, CMS wanted to eliminate the need for "defensive" EMTALA compliance in those gray areas in which providers had a hard time knowing whether the law applied or not. In many cases, providers played it safe by using EMTALA protocols and that led to an unnecessary burden, she says.

For instance, some providers thought the rule applied to patients who came to the hospital for outpatient care such as lab tests. They were in the hospital, so some providers interpreted EMTALA to mean there was an obligation to provide screening. The final rule makes clear that such practices are not necessary, Yeh says.

"If you develop an emergency on your way to the appointment or need emergency help, then EMTALA applies," she says. "But if you're being treated in rehab and develop chest pains, then the other hospital outpatient conditions of participation apply and you don't have to apply EMTALA." ■

EMTALA Q & A

'Just the facts' not enough if patient asks about bill

Person must be 'encouraged' to stay

[Editor's note: This column runs occasionally in Hospital Access Management and addresses questions regarding the Emergency Medical Treatment and Labor Act (EMTALA).]

Question: Is it true that we can violate EMTALA by not encouraging a patient to stay for treatment when he wants to leave? We've been told, for instance, that if a patient asks about financial liability for treatment, we must actively encourage the patient to stay until he can be examined rather than just stating the facts about payment.

Answer: You're right that you can violate EMTALA this way, says **Susan Lapenta**, JD, a partner with Horty Springer, a law firm in Pittsburgh that specializes in health care issues.

This facet of EMTALA is particularly confusing to health care providers, who often are surprised to learn that they violated the law when they merely answered a patient's question honestly and politely, she says.

To fulfill the intent of EMTALA — ensuring that people who need urgent care are not turned away from hospital emergency departments — the government expects providers to go beyond simply answering a question about possible financial liability. ED staff should actively encourage people to stay for treatment even if they are concerned about the ability to pay, Lapenta says.

"It's not enough to answer a question about payment factually and accurately," she says. "The

government is looking for the hospital to reassure patients, to say, 'Don't worry about payment. We'll take care of you.'"

The concern is that if you simply provide the facts about payment, a patient will leave the ED because of payment concerns when he or she actually has a medical condition that needs to be treated, Lapenta says. "The government considers [it] your responsibility to prevent" this from happening, she adds.

The issue can trip up ED staff because they often think of EMTALA violations as overt acts in which the staff purposefully turned the patient away. That is a dangerous misconception, warns Lapenta.

ED staff might not understand this point, she says. "I suspect they know in a general sense that they're not supposed to talk about payment, but I'm not sure they fully understand that the government expects them to actively encourage people to stay for treatment. It confuses people when they know they meant no harm and didn't initiate the conversation about payment to try to scare people off."

The government has spelled out what it expects of ED staff in this situation, Lapenta says, and the bar is set pretty high. In an advisory bulletin issued in 1999, the Health Care Financing Administration — now the Centers for Medicare & Medicaid Services (CMS) — explained exactly what the ED staff should do in response to a question about financial liability. (Financial inquiries are addressed in item 4 in the bulletin.)

In a nutshell, she explains, the government expects ED staff to gently reassure people that they will be treated as needed without regard to payment, going to great lengths if necessary to avoid answering the question directly.

If the patient is insistent and keeps pushing for a straight answer, the government does allow the ED to respond, but only after a verbal tango in which all attempts to elude the answer are exhausted. The staff member has to work through a series of steps choreographed to reassure the patient and deflect payment inquiries. No matter how reasonable and serious the question sounds at first, she adds, you can't just blurt out the facts and let it go at that.

The Bush administration is sending signals that it is more flexible in investigating such slip-ups, Lapenta notes, whereas the previous administration took more of a hard-line approach.

Of course, an EMTALA investigation is bad news even if you prevail in the end. Thus, Lapenta advises taking the necessary steps to educate ED staff, especially those involved with patient triage and intake, about this particular risk with EMTALA. Some hospitals script out what employees can say, which she says can be a good idea.

Lapenta suggests a script that goes something like the following in response to the first question, with parts repeated as necessary if the patient persists in asking: "You need to be taken care of first. That's our first concern. We can talk about money and what you might have to pay for later, after we make sure that you're safe. We have to do this screening examination first to make sure that you're OK, and then we can talk about payment later. We'll answer all your questions about that soon, but we really need to concentrate right now on making sure you're OK," she adds.

Educating staff is a key concern with EMTALA because, if a complaint arises, investigators will take a hard look at whether a patient was illegally diverted intentionally or because staff weren't adequately trained in EMTALA compliance. Either of those conclusions is much worse than staff simply making a mistake with one patient.

"The government is usually more concerned with whether staff are trained properly than whether they slipped up one time," Lapenta says.

[For more information about EMTALA, contact:

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Registrar prevents identity fraud attempt

Training initiative laid the groundwork

The emphasis by Milwaukee-based Aurora Health Care's training and data quality team on making sure registrars were well acquainted with the system's process for preventing identity fraud paid off recently, says **Sue Underbrink**, CHAM, supervisor of metro patient access training and data quality.

"An individual had been accessing Aurora Health Care for services using multiple aliases," Underbrink adds. "A registrar at one of our facilities was instrumental in stopping this individual from continuing to commit identity

(Continued on page 117)

Patient Identity Fraud Policy

PURPOSE:
To protect customer identity, maintain the integrity of the medical record, and facilitate billing and collection of patient accounts

POLICY:
Patient Access will follow appropriate procedures to ensure protection of patients, providers and payers in regard to patient identification and fraud prevention for Aurora Health Care.

PROCEDURE:

- **Prevention Measures**
  - A photo ID and an insurance card will be requested and copied during each registration performed. The time of this request for emergency or urgent care patients should occur following medical treatment to satisfy EMTALA standards. Patients who object to providing these documents are to be advised this process is for their personal protection as follows: "We ask for these documents in an effort to reduce identity fraud. Our desire is to protect your insurance information and medical record, and to properly bill your account."
  - If ID fraud is suspected the during the registration process, the registrar will:
    1) Complete entire registration as usual;
    2) Notify clinician staff of possible fraud;
    3) Notify supervisor who in turn will notify Loss Prevention, Medical Records, Corporate Compliance, and then the Director of Patient Access. (If notification is done by e-mail never mention patient name or MRU in the subject line. Please make sure that the e-mail has a confidentiality statement attached.)
  - If while registering a patient utilizing historical data the alternate name field indicates a first name beginning with Fraud and the last name Doe, and the patient is unable to provide a picture ID confirming they are who they claim to be, this would be a clear indication that identity fraud is about to take place for a second time. In this instance, the registrar should excuse himself/herself from the patient and immediately notify a member of management who will contact Loss Prevention.
- **Correction Strategy Once Fraud Confirmed**
  - Upon notification of an incidence of fraud via receipt of the affidavit, PAS will:
    1) Create a new MRU as follows:
       - Last name = Doe
       - First name = Fraud followed by victim last name as all one word. (Example: FraudSmith)
       - Date of Birth = Admit date of service for case involved in the fraud
       - Alternate Name field = Name of victim of fraud (Example: If new registration is created for FraudSmith Doe, the alternate name field will show the victim name Joanne Smith)
    2) Revise original registration by entering the alternate name field with the patient name used to create new MRU (Fraud{insert victim last name}Doe)
  - E-Mail CIS Site Supervisor that above transactions have been completed.

Source: Aurora Health Care, Milwaukee. Used with permission.

fraud by following Aurora's Patient Identity Fraud Policy. **(See policy, p. 116.)**

"The quick action of the registrar resulted in an on-the-spot arrest and filing of multiple charges against this individual," she notes.

A training initiative Aurora implemented earlier this year helped ensure that registrars understand the importance of accurate patient identification, Underbrink says.

"[Trainers] went out and sat with every registrar and observed the entire process for three to five registrations," she explains. "We have a policy in place, a requirement that registrars ask for a photo ID."

What trainers observed was that registrars consistently asked for the ID and copied it, but that they weren't really looking at it, Underbrink notes. "Because of that observation, and getting feedback to [employees], we think it's getting better."

During that initiative, which examined the quality of all registration functions as well as the ID requirement, trainers provided individual feedback on each registrar, and a summary of overall departmental performance, she says. In the first half of 2004, the team will follow up to see if improvements have been made.

"We will go back and spend one to three days [at each hospital] and just take a look," Underbrink says. "Are they asking the Medicare Secondary Payer [MSP] questions, or are they assuming the answers?"

Trainers had observed that registrars asked the MSP questions in such a way as to lead the patient to say no, she says. "They would say, 'You've never had a kidney transplant, have you? This isn't workman's comp, is it?'"

After the feedback was provided, Underbrink adds, improvements were made, as with the patient ID policy. "[Before] they just didn't understand the importance of what they were asking." ■

Proper patient ID focus of hospital initiative

Effort targets intentional fraud, human error

With patient safety a heightened imperative from Joint Commission for the Accreditation of Health Care Organizations, and facing its own duplicate medical record problem, Truman Medical Center in Kansas City, MO, launched an initiative aimed at ensuring proper patient identification.

The challenges are myriad, explains **Nancy Stringer**, director of patient access. "Some [of the problem] has to do with patients coming in and being one person one time and another the next time."

A man who knows he needs a particular medical procedure may use his brother's Medicaid card to try to make sure the cost will be covered, she adds. "Or a person is in the country illegally and someone loaned him a visa to use."

Then there are the cases in which someone is Willie Williams on one hospital visit, William on the next, and Billy in a later encounter, Stringer says. Adding to the mix — which of course also includes normal human error — are cases in which people give inaccurate Social Security numbers, she notes.

The hospital is addressing the problem on several levels, Stringer says, with educational efforts targeting registrars, clinical personnel, and patients.

"We are making sure registrars understand proper search criteria," she adds. "For example, we probably have 40 or 50 Bob Smiths. We're telling them to use multiple criteria when they put that name into the system. If there's no match using name and birth date, don't give up and add a new patient. Try the Social Security number — maybe the [patient's existing file] is under Robert Smith."

In addition to educating registrars, Stringer notes, the hospital also is looking at getting registration software with a feature that searches for names that sound like the one being entered.

The idea behind educating care providers, she explains, is that they often are privy to information that patients may hide from registrars.

"Sometimes the person is afraid because, for example, they may have [outstanding] tickets or warrants against them and feel we might notify someone about that," Stringer says. "So they use their brother's name or birth date."

When the care provider begins taking the person's history, but is looking at the brother's chart, she adds, the deception may eventually be uncovered during their conversation. Other times, she says, the patient may have trouble communicating for one reason or another [during registration], but when the family comes in later, the family clears up the confusion.

With these kinds of scenarios in mind, clinicians are being urged to share such revelations with registration personnel, she notes. "It's

everybody's responsibility to make sure we have accurate information."

Patients, meanwhile, are being targeted with an effort called Operation Identification, Stringer says. "We will do a campaign about why [proper identification] is important."

The hospital's public relations department is working on a flyer — using the colors red and black to make it stand out — that stresses the connection between proper identification and good medical care, she says.

The flyer will encourage patients to bring along information to verify identity, and to give the same form of their name on each visit, Stringer adds. "It will be displayed at registration sites for patients to pick up," she says, as well as being handed out by registration staff.

In conjunction with the new emphasis by the Joint Commission for the Accreditation of Healthcare Organizations on patient safety, Stringer notes, the proper identification focus will extend throughout the organization.

For example, she adds, "When clinicians do a procedure, they will use dual identifiers, such as [checking] the armband, [checking] the birth date, to verify that this is 'Suzie,' as well as going over it verbally with the patient."

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Cream puffs, quilts, and competency tests?

State fair theme educates with a fun twist

When the training and data quality staff took over the competency assessment of patient access employees at Milwaukee-based Aurora Health Care, they added a little regional flair to the process.

A competency fair, which is inspired by Wisconsin's popular state fair, replaced the previous practice of having supervisors with checklists review critical functions and material with individual registrars, says **Sue Underbrink**, CHAM, supervisor of metro patient access training and data quality.

"We wanted to do something that people would learn from and also have some fun," she adds. "Anyone who knows Wisconsin knows that cream puffs are a big deal. We decided to go to each hospital, provide refreshments and be there for several hours."

Required by the Oakbrook Terrace, IL-based Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the annual assessment also is documented for inclusion in each employee's personnel file, Underbrink notes.

To ensure that all competency-related bases were covered, she says, she and her team of two training specialists developed four categories of competition for the assessment, each with its own fair-related theme.

Employees participated in three or four categories, depending on whether they were qualified as schedulers. "The way our jobs are set up, we have [positions designated] patient access specialist, and then levels one and two," she adds. "Level twos are expected to know more. Some people schedule, but also register."

Here are some of the categories:

• Customer service/Ticket booth

Patient access employees attending the fair first encountered a ticket booth where they were asked to pull the appropriate "ticket" (answer) and — using Velcro — attach it to the correct spot on a poster containing 20 customer service-related questions, she explains.

As with the other competency categories, employees who couldn't be there in person — or preferred to answer questions the more traditional way, using pen and paper — were given a hard copy of the quiz to fill out, Underbrink says. In those cases, her staff corrected the papers and sent them to the person's supervisor.

"There were very few [who didn't participate in the fair]," she adds. "We kept that to a minimum."

• Regulatory issues/Prize-winning patchwork quilt

In the next event, employees assembled a prize-winning patchwork quilt by placing the correct quilt piece (question) to the spot on the "quilt" — a brightly colored poster — with the corresponding answer.

For example, the first question was: "[Blank] is the regulatory agency whose mission is to protect the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations," Underbrink says. "We did a lot of work [in advance of the fair] making sure everybody understood what JCAHO is."

Other topics included the Emergency Medical Treatment and Labor Act, the Medicare Secondary

Payer questionnaire, the Health Insurance Portability and Accountability Act, and the Centers for Medicare & Medicaid Services.

For the regulatory portion of the fair, which was fairly lengthy, employees were allowed to work in teams. At least one member of the training and data quality staff also was on hand to monitor the process, Underbrink adds, so that one person didn't answer all the questions. "We made sure it was a real team effort."

• **Registration/Prize-winning sunflower**

To "grow" the winning sunflower, employees placed petals — each with one of 28 registration questions — on a huge sunflower poster containing various answers. In this case, topics were drawn from the highest-ranking errors tabulated from quality audits, she points out. "We wanted to find out what they knew *and* help educate them."

For example, questions were asked regarding the definitions of physician type, Underbrink notes, since audits had revealed some confusion over whether a physician was "admitting," "attending," or "ordering."

Also addressed was the topic of identify fraud, she says. "We process a process to prevent that, and we wanted to make sure people knew it." **(See related story, p. 115.)**

As with the regulatory quilt, the registration sunflower usually was a team effort.

• **Scheduling/Prize-winning pie recipe**

Only employees who performed the scheduling function entered this competition, in which 10 questions and answers formed the winning recipe. "We actually had answers on pie dough with rolling pins," Underbrink says.

The training and data quality team took its competency fair on the road — staging it at five Aurora hospitals and at one urgent care clinic, where staff from a second clinic joined the process, she notes. "At least 100 [employees] were involved," Underbrink adds, whether in person or through answering the questions on paper and submitting them later.

At one hospital, the fair was held in the evening, in conjunction with a regularly scheduled staff meeting, while at the two largest facilities the event went on all day, she says. "We were there early enough that the night shift could stay over and participate, and late enough to catch the evening shift."

Although the competency assessment typically happens in the fall, the 2002 event was a little late, and actually occurred in January, Underbrink adds, still early enough to figure into employee evaluations.

The 2003 assessment will take place before the end of the year, she says, but with one major change. This time, it will be conducted via Aurora's registration training and support web site.

[Editor's note: Sue Underbrink can be reached at sue.underbrink@aurora.org.] ■

AHA urges CMS: More transactions guidance

Recent guidance by the Centers for Medicare & Medicaid Services (CMS) on Health Insurance Portability and Accountability Act (HIPAA) transactions standards did not go far enough, says the American Hospital Association (AHA), which has urged CMS to respond to what the AHA calls critical issues that have not been addressed.

The Health Insurance Portability and Accountability Act's transactions standards take effect Oct. 16.

While the CMS guidance recognized the importance of maintaining uninterrupted payment for hospitals and other caregivers, it failed to outline a contingency plan with specific actions to prevent disruptions to the payment cycle, said **George Arges**, senior director of AHA's Health Data Management Group.

Arges, speaking to a subcommittee of the Department of Health and Human Services National Committee on Vital and Health Statistics, also said that CMS should make clear that health plans can process a claim if it has nonmaterial errors and should not reject an entire

batch of claims because one or a few contain errors, as well as what specific actions demonstrate good-faith efforts to implement the standards.

HIPAA security rule

In another HIPAA matter, AHA has issued a regulatory advisory to its members on the final security rule, which was published Feb.20. Hospitals must be compliant with that rule by April 21, 2005.

The regulatory advisory, developed with the consulting firm of Ernst & Young, describes the rule's core requirements for hospitals, highlights significant differences between the final and proposed rules, and suggests how hospitals can jumpstart their security efforts by leveraging medical privacy rule compliance information and resources.

The advisory also identifies the key challenges that hospitals face in implementing the rule, and recommends how they can avoid these potential pitfalls. AHA members can read the advisory online at www.aha.org. ■