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American Health Consultants® is A Medical Economics Company

Easy-chair entry: Is the patient's living room the access center of the future?

Internet solutions shift scheduling, registration focus

What if overburdened access departments — faced with dwindling staffs and bare-bones budgets — could shift much of the responsibility for scheduling and registration to the patient? That's a not-so-distant scenario, thanks to inroads being made in using the Internet for health care communications, says **Michael Kaufman**, vice president of new business development for Delray Beach, FL-based Eclipsys Corp. Furthermore, patients will welcome this opportunity to take control of their own health care destiny, Kaufman suggests.

At least one Eclipsys client, Newton Wellesley Hospital, part of the Boston-based Partners Healthcare System, has patients filling in their own demographic information and medical histories on electronic tablets as they wait to see a physician, he notes. "The patients, especially the older ones, like it because it allows them a chance to give information that, because of time, they can't give to the physician during their appointment," Kaufman says.

The future of access management and the Internet is now.

Since it takes a 45-minute interview to obtain the average woman's medical history, and most physician appointments last closer to 15 minutes, the potential for efficiency and quality improvement is obvious, he points out. The logical next step, he says, is to have patients complete that medical history form via the Internet before their appointments.

With patients e-mailing requests for appointments, on-line physician referrals, and instant checks for insurance eligibility, the future of access management and the Internet is now, says **Stephen Sullivan,** MD, vice president for product management at Dallas-based Healthvision. That company, founded by Eclipsys and the Voluntary Hospital Association in Irving, TX, was created to pursue Internet health care solutions.

Health care organizations with cutting-edge access management, Sullivan says, are focusing on these areas:

• putting Web-based "front ends" on traditional registration systems;

• interactive patient care, with patients given more and more access to the health care organization's database.

An electronic data interchange product from Envoy Corp. being marketed by Healthvision allows health care providers to look directly into a payer's database to check eligibility, notes Sullivan.

Nearly all providers using software

Nearly all of the health care providers in Santa Cruz, CA — including two competing hospitals and two managed care organizations — use Elysium, a product of Mountain View, CA-based Axolotl Corp., to share clinical data. The community's 160 physicians, most of whom work with a large independent practice association (IPA) that holds the managed care contracts, use Elysium for on-line authorization and referral requests, with a savings of $13.79 per request, says **Steve Sedlock,** Axolotl vice president.

The problem in Santa Cruz, explains Sedlock, was that physicians spread over a large geographical area faced ongoing "telephone tagitis" in trying to communicate with their colleagues. "The referral process is generally physician to physician, or supporting staff to supporting staff," he points out, "but most of the time the physicians are seeing patients. Either way, someone has to track the physician down to relay questions."

With Elysium, Sedlock says, the authorization or referral request is embedded in an e-mail form, with all the relevant patient information tagged to that form. Three key items are required:

• patient demographics, including insurance information;

• medical notes and history;

• appropriate ICD-9-CM and CPT-4 codes for authorization requests.

"It's just common sense that there will be less back-and-forth dialogue between whoever's initiating the request and the recipient, whether it's another physician or an authorizing agent," he adds.

The process works as follows: "The physician fills out the form on the computer and routes it to the computer of the IPA that serves an MSO [medical services organization] function," Sedlock says. "There is software on its side that maintains eligibility and benefits databases. The elements in the form the clinician completes are checked against the database. If approved, an automated approval is queued back in a few minutes to the physician or health care administrator."

The system allows either the referring physician or the referred physician to look up authorization status quickly, he adds.

When a patient is admitted to the Baptist Health System (BHS) in Jackson, MS, an information sheet is automatically sent by computer or fax through Elysium Access to the office of physicians listed as *admitting*, *referring*, or *consulting* on the admission form, says **Maribeth Slinkard,** director, regional health care information services.

Clinics get timely information

About 200 BHS-affiliated physicians use a standard Web browser to receive admission / transfer / discharge information, as well as laboratory results, transcription reports, and radiology results, Sedlock notes.

"The information sheet provides demographic and insurance information about the patient being admitted," Slinkard says. Clinics receive the information in a timely and reliable manner "without having to place a phone call and wait on 'hold' or depend on hand delivery. Cost reductions have not been tracked, only talked about, but when you reduce the amount of time clinic personnel spend on a process, you save dollars. Clinic satisfaction with this process is high."

The BHS business office also benefits from the process, Slinkard notes, because calls for information are reduced.

From an access management perspective, the efficiencies of interactive patient care are virtually limitless, Sullivan notes.

With patients sending in requests for appointments, access personnel "can perform their tasks in an asynchronous fashion, when they want to, without phones ringing in the background," he adds. "It will be a much more controlled environment."

Patients send e-mails

That environment exists now at Boston-based Partners Healthcare System, for example, where access personnel can work a queue of e-mail messages from patients who have sent their appointment requests through the system's Web site (www.Partners.org).

"What's very interesting to us," Sullivan says, "and we expect this soon, is being able to expose a bill through the Web, in a secure system. If the patient owes a balance of $150, they can pay that, as well as paying the co-pay on-line before the visit. We're looking at which institutions want to do it."

Consumer concerns with Internet security constitute one obstacle to widespread e-commerce in health care, Kaufman acknowledges. "Many people will give their credit card number over the phone easily but won't give it over the Internet."

However, he sees that reluctance disappearing as people become more comfortable with paying all kinds of bills on-line.

This kind of e-commerce, he notes, is particularly significant for hospitals, which struggle to achieve timely bill collection. "It gives the patient the ability to see the problem [with a bill] immediately instead of having to call back and forth."

Provider surveys, Kaufman points out, have shown that the majority of calls to hospital billing offices are patients asking why their insurance didn't pay. In other cases, when rejected bills are sent to patients, they simply don't respond at all, he adds. "With an account on the Internet, you can get to them through e-mail."

Ultimately, he says, the idea is that the patient — having already checked in via the Internet and perhaps settled the co-payment — simply will show identification and go directly in for service. The patient registration department of the future, he suggests, could be the patient's living room. ■

Consolidation is the way, says health system VP

Politics called No. 1 obstacle

Establishing a consolidated business office (CBO) for Baptist Health System (BHS) in Birmingham, AL, has resulted in cost-savings, quality improvement, and dramatic reductions in bad debt and accounts receivable (AR) days for the 10-hospital system, says **Mitzi Winters,** CHAM, CHFT, vice president of patient business services.

Since 1994, when the two largest hospitals — Montclair and Princeton — merged their business offices, the system has reduced bad debt from 3% to 1.9%, and gross AR days from "the low 60s" to 50, Winters says. The last of the 10 hospitals was added to the CBO fold in April 1999.

Winters, then director of one of the business offices, was asked to write a proposal for the Montclair-Princeton consolidation in January 1994, and "we were fully merged by May," she notes. With long-range plans in place to install computer systems from Malvern, PA-based SMS at the other eight hospitals, the decision was made to merge each hospital's business operation into the CBO as the computer conversions were done.

Without the computer installations, she estimates, it would have taken about three months to add each hospital to the CBO.

When the first two hospitals merged business operations, there was an immediate reduction in staff of 8.5 full-time equivalent (FTE) positions, several of them management-level, Winters says. There also were savings in terms of space from moving the remaining 26 employees at Princeton to the Montclair campus, she adds.

The FTE reductions continued as the consolidations progressed, Winters says, but not one of the affected employees has left the system. They either have been offered jobs at the CBO or have found positions elsewhere in the system, she adds. "We work with human resources at the individual hospitals and get them preferential treatment for jobs that are open. We've really worked hard at that."

While it was putting the CBO in place, Winters says, BHS made a commitment to strengthen the admitting function, with a concerted effort to improve data accuracy and increase upfront collections. Under the reorganization, each hospital has its own admitting director, who interfaces

with the CBO and reports to a corporate director of admitting for the entire system, she adds.

There is at least one financial counselor at each hospital to take care of charity applications and payment arrangements for walk-in patients, she explains. Otherwise, all business operations are handled at the CBO.

"All of the training for admitting is done at central — how to ask for a deductible, how to fill out forms," Winters says. "[New employees] don't touch a computer until they come to the CBO in Birmingham for four days of training, so we really put a lot of emphasis on that training."

That emphasis has paid off with a big improvement in quality, she notes. When BHS began audits of admissions in 1994, along with a quarterly incentive plan, the systemwide average was a 72% correct admission, she says. It is now 98.5%.

Like many admitting departments, those at BHS find themselves losing the admitting representatives they've trained to better-paying jobs with regular hours after a year or so, she notes. The good news is that instead of going to insurance companies or physician offices, the BHS reps tend to move to the CBO. "At least we keep them in the system."

With nine colleagues to call on, in addition to the corporate director, each hospital's admitting director has a built-in network for ideas and problem-solving, she points out. "Instead of calling a competing hospital for help, they've got nine people within the system to call at the drop of a hat. There is a lot of shared experience."

When a new admitting director is hired, Winters says, an experienced director from another BHS hospital is sent to work with that person.

The biggest obstacle to a successful CBO implementation was the politics involved in removing the business function from the individual hospitals, she says, and it was a challenge that was not taken lightly.

"Even though there was a corporate directive to [make the change], there was a lot of effort spent with each hospital administrator to make them understand the advantages," Winters says. "I spent a lot of time with the administrators explaining how we would be handling patient accounts."

Among the benefits of a CBO, she points out, is the availability of technology small hospitals couldn't afford. "We've improved statement formats, put in better telephone systems that are automated, and our remits are done electronically. We've got a [predictive] dialer that cost several hundred thousand dollars — there's no way a 100-bed hospital can afford that."

To help prevent customers from thinking of its CBO as "that office up in Birmingham," BHS set up local telephone numbers at individual hospitals, she says. Customers with account inquiries make a local call, which is rolled over to the central office, Winters says.

Having an admitting director in place at each facility is a key element to the CBO's success, she notes. "They understand what we're doing at the corporate level and support it. A few [directors] had to go because they were not able to make that switch. It can be very much of a public relations nightmare if you don't have the support of people at the local level."

The compliance factor

Increasing government scrutiny of billing practices gives even more reason for health care organizations to establish CBOs today than when BHS did so five years ago, Winters points out. "In 1994, billing was still an easy function. But with today's fraud alerts and audits, it's very important that whoever is responsible for putting bills out is up to date. If you have just 12 employees [in the business office], there's no way you can be as up on things as someone over a 500-bed hospital."

The CBO's increased buying power, she adds, enabled the purchase of software — such as Omega, a program from Atlanta-based NDC — that performs medical necessity audits.

Similarly, Winters has been able to hire a director of compliance who "does nothing but read the literature on medical necessity and work with the different hospitals" and a nurse who tracks medical necessity issues and addresses problems that arise. "[Compliance] is a big deal. Most hospitals don't even know how much money they're losing because of this."

In January 1999, BHS started tracking the procedures it was unable to bill for because of failure to document medical necessity properly, Winters says. As of July, the money lost each month has been reduced from $700,000 to $450,000, she adds, and the goal for the upcoming year is $350,000. "That's probably the No. 1 thing we're working on," she says. "If we didn't have a CBO, who would be doing that?"

(Editor's note: Look for a full report on Baptist Health System's medical necessity program in the next issue of Hospital Access Management.*)* ■

Changes could put EDs out in the cold

Long-awaited APC plan finally on the horizon

New billing regulations for Medicare patients will lower reimbursement and put some EDs in financial jeopardy, predicts **Michael Bishop**, MD, FACEP, vice president of the American College of Emergency Physicians (ACEP) in Dallas.

Access managers who oversee emergency departments should alert administrators and physicians to the changes, which likely will mean less payment for outpatient services provided to Medicare beneficiaries, he says.

Although ED patients already are guaranteed access to care under the Emergency Medical Treatment and Active Labor Act (EMTALA), financial ramifications could create barriers to care, says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA. "If the payment levels are insufficient, you might not only see hospitals closing, but some hospitals may pull out of outpatient and emergency services," she predicts. "If that happens, it will create an access problem."

"Obviously, if you cut up to 15% of patient reimbursement for emergency services, that will have a significant financial impact on the hospital," Bishop notes. "If your costs are going up and your payments are cut, then it's a double whammy." ED managers will need to provide the same services for less money, which is a formidable challenge, he explains.

The financial impact may be so devastating that some EDs may have to close their doors. "You need to be concerned about the financial viability of your institution," warns **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

"There could be huge shifts in volume of outpatient surgery in competitive markets. The need to meet the competitive price may affect the financial viability of the institutions, and it will definitely affect their cash flow," he explains.

"This is so broad-sweeping, it has potential financial ramifications for literally every ED in the country," emphasizes Bishop, who served on an ACEP task force that commented on the regulations.

The long-awaited plan from the Health Care Financing Administration (HCFA) in Baltimore will shift outpatient reimbursement for hospitals into ambulatory patient classifications (APCs) similar to the diagnostic related groups (DRGs) for inpatient payments. The proposed system groups more than 5,000 outpatient codes into 346 payment groups, or APCs. "Each APC has been constructed to include a related group of clinical services for which Medicare will reimburse hospitals at a single, predetermined rate," Smith explains. "So APCs substantially reduce the number of payment levels that need to be tracked."

To define the clinical services included in each APC, HCFA will use the same coding system currently used to reimburse physician services for Medicare patients, known as the current procedural terminology (CPT) system.

"This would be a major change in how billing is done. It represents the same magnitude of change as the switch to DRGs on the inpatient side," Yeh says.

Biggest billing change in a decade

This is the biggest reimbursement change in Medicare billing since 1982, when the Tax Equity and Fiscal Responsibility Act was passed, Bishop points out. "That caused many emergency physicians to do their own billing instead of the hospital. This change will have no less of an impact on EDs."

The regulations will control the growth of Medicare expenditures for hospital outpatient services the way the DRG reimbursement system controlled inpatient expenditures. "The Medicare strategy is simply to treat hospital outpatient services exactly the same way as they treat physician office services, which is a totally new approach," Smith says.

Explains Bishop, "This is a move by HCFA to decrease Medicare costs, which is not a bad thing, but there are potential problems. In the ED, we can't control the patients we see, so we see the sickest patients. If the amount of revenue goes down for the hospital, we will have less money to provide the same services."

As a result, patient care could be affected. "This can certainly affect patient care if there is not as much money coming in to the hospital. Decreased payment could result in decreased staffing, equipment, and supplies," Bishop says.

Some hospitals will be affected more than others, he warns. "Teaching institutions and large inner-city hospitals, any hospital that has a high percentage of high-acuity or Medicare patients, will be hit the hardest."

Hospitals should expect less payment for outpatient services provided to Medicare beneficiaries, both from Medicare payments and copayments from beneficiaries, says Smith. "HCFA predicts reductions in direct payments from the Medicare program amounting to 3% to 15% of current revenue. The actual impact on individual hospitals will vary based on the hospital's current cost-to-charge ratio."

Copayments will be reduced from current levels by an unspecified amount. "Estimating the amount of this reduction is very difficult," says Smith. "Comparing the maximum and minimum copayment amounts for common procedures suggests that the eventual reduction will average 13% of total payment. More than 50% of the revenue reduction will result from lower beneficiary copayments."

The impact on hospitals will depend on the amount of copayment they charge. "A hospital has to choose whether to charge the maximum or minimum allowable copayment, or some number in the middle," says Smith.

Stay on top of this issue

Keep your staff informed so the change doesn't take them by surprise, Bishop advises. "Most ED physicians don't know much about this, so ED access managers need to get the word out that this is coming. Inform staff and hospital administrators about the potential ramifications of this."

Also, keep abreast of new developments, Yeh recommends. "ED managers should stay in touch with hospital administrators and work with trade associations like the American Hospital Association [AHA] and the American College of Emergency Physicians to make sure our voices are heard."

Many access managers in the ED are not prepared for this change, says Smith. "It is a sleeping issue because it's been expected for so long and has been put off so many times," he explains. Implementation originally was scheduled for Jan. 1, 1999, but the date has been moved to April 2000.

A draft of the proposed regulations was published by HCFA, and comments on the preliminary rules are being reviewed, notes Smith. The final rules will be published 90 days before implementation. The delay is due to HCFA's problems with the Y2K computer bug.

"Hospitals will need the intervening months to prepare for the operational changes required or billing of outpatient services and to plan their response to the market changes that the new Medicare payment system is certain to cause," says Smith.

EDs may come out ahead

Although the overall impact on hospitals will be negative, it's possible that EDs may benefit from the change financially as individual departments, says Smith. "The EDs are actually going to come out ahead rather than behind, because in general they do less-complicated cases, compared to the rest of the hospital," he explains. "EDs do have very complicated medical cases, but there is a built-in filter so we don't get the worst surgical cases."

The change will directly increase the revenues attributed to the ED. "The ED will become a revenue center instead of a loss center," he predicts. "For example, for an IV administered, right now the only payment the average ED gets is whatever is included in that visit level."

When the new regulations take effect, EDs will get credit for both the visit and the procedure. "If that IV is billed under a revenue code for the pharmacy, then the charge will be denied because it's bundled into the visit service," Smith says. "The $100 paid for that IV needs to be billed by the ED revenue code, not under the pharmacy code."

The ED then gets credit for the payment, he explains. "So the pharmacy becomes a supplier of material to the ED. The gross revenue of the ED will go up, and dramatically down for the pharmacy," he says.

If HCFA decides to make its payment decisions based on the patient's symptoms and services received instead of the eventual diagnosis, that could be a positive change for emergency medicine and patients, Yeh says. "We will finally have some policy recognition that a diagnosis is not what drives emergency care," she explains.

If the fee schedule allows for payment for services required under EMTALA, including medical screening exams and stabilization, that would be another plus, she says. "There should be some payment recognition for EMTALA-mandated services, which we have an obligation to provide," she stresses.

Following are explanations of the two major changes that EDs are expected to make in response to the regulations:

1. **The existing cost-based reimbursement will be replaced with a prospective payment system.** Hospitals will be required to report outpatient service charges using a standardized coding system. ED charges will be submitted based on the APC coding system for procedures**.** "HCFA's reporting structure is the same one currently in place for physician services," Smith explains.

Currently, Medicare pays emergency departments for supplies and medications used in a procedure, not the procedure itself, notes Smith. "Now Medicare will pay for the service of injecting a drug, instead of paying for the drug or supplies consumed in a procedure."

Hospitals are paid based on costs, but they now will be paid based on the APC fee schedule. "The amount that will be paid for a particular CPT code will be grouped with other services," he says.

The APC system groups services together and pays a present average fee for that group of services, which reduces the total number of payment levels. "The principle is, the payment for a laceration is averaged across all lacerations. For instance, all laceration repairs at the simple or intermediate level are grouped into a single category," says Smith. "So the hospital payment will be the same for a 1-inch laceration as it is for a 5-inch laceration, whether it is a layered closure or not."

2. **Payment rules for physician offices and hospital outpatient services will be standardized.** According to HCFA, the proposed prospective payment system for outpatient services is designed to create a "level playing field" where the same payment methodology is used to reimburse for a service, regardless of where it is performed. However, the same payment rates won't necessarily apply to different settings.

"Implementation of these proposed rules will impose on hospital outpatient services the payment rules that HCFA already applies to physician services," says Smith.

[Editor's note: The complete regulations can be reviewed on the Federal Register Online *(Sept. 8, 1998) Web site. Web: www.nara.gov/fedreg. Information also can be obtained from the American Hospital Association at www.aha.org.]* ■

Is your ergonomics policy working as it should?

If not, employee health suffers

Are your access employees ergonomically correct when it comes to computer and desk placement, posture, and the need to take frequent stretching breaks?

To ensure that its staff can answer "yes" to that question, ScrippsHealth in San Diego has moved into high gear with its Ergonomic Work Site and Job Duty Evaluation Policy, says **Vicky Tickel,** government billing manager. Increasing staff awareness of the policy was prompted in part by ScrippsHealth's need to establish documentation of its practices for certification to the ISO 9002 quality management standard, Tickel says.

"We're educating staff so they're aware of signs [of repetitive-stress injury] and of what to do throughout the day to prevent injury," she adds. **(See tips on preventing injury, p. 117.)**

Employees encouraged to be proactive

The goal is for employees to alert managers at the first sign of problems, not to wait until the damage has been done, Tickel says.

"We're not all the way there," she notes. "We have some old desks, and not all have been updated." However, "all have been evaluated, and we have ordered enough equipment to get to the point that employees are comfortable." One goal is to move toward more paperless procedures, because having more space on a desk is an ergonomic advantage, she notes.

Solutions are tailored to employees' needs, Tickel explains. In the case of one woman who was on and off the job with workers' compensation claims, an egg timer was used. "When it went off, it would prompt her to get up and do stretches and hand exercises, which were modified specifically for her."

In some instances, follow-up workstation evaluations are done, she notes. "Maybe we did an ergonomic review, ordered the equipment necessary, and the employee is still having problems," Tickel says. "We ask a physical therapist to come and see if [the employee] is sitting properly, if the

(Continued on page 117)

VDT Work Site Evaluation

1. VDT

a. Screen in line with the keyboard Yes____ No____

b. Top ⅓ of screen at eye level Yes____ No____
(Consider multi-focal eyeglasses)

c. Screen at 18" - 28" viewing distance Yes____ No____

d. Appropriate copy holder available Yes____ No____

e. Glasses worn Yes____ No____

Type?_____

Do you wear them? Yes____ No____

Last time eyes were checked _____

f. Does CPU compromise work surface? Yes____ No____

g. Lighting:

____Above ____Behind ____On Desk ____Absent

____From Right ____From Left ____Fluorescent ____Diffused

____Windows Location: _____

h. Daily use of computer: ____<25% ____25%-50% ____>50%

Comments: _____

_____

_____

_____

_____

2. Chair

Chair is adjustable in the following manner:

____Height ____Rocking chair motion

____Backrest height ____Rocking chair tension

____Backrest depth ____Built-in lumbar support

____Seat pan angle ____Five-point base

____Back/seat pan independent ____Arm rest

a. Adjustable to both work height and person? Yes____ No____

b. Does one person use the chair? Yes____ No____

c. Does chair fit under desktop to provide appropriate positioning of shoulders? Yes____ No____

Source: Scripps Health, LaJolla, CA.

desk is at the proper height and the computer at the proper location on the desk."

Under consideration is a computer screen saver that periodically flips into an ergonomics program, alerting the employee that it's time to stretch or do hand exercises, she says.

The organization's Ergonomic Work Site and Job Duty Evaluation policy gives detailed instructions on when evaluations should be conducted, who's responsible for doing them, and which department should be charged for any expenses incurred — when a physical therapist is called in, for example.

Conduct evaluations periodically

The policy calls for conducting evaluations in the following situations:

- during a new employee's orientation to work site or duties;
- when requested by a manager in response to an employee inquiry;
- when an employee's work site and / or job description significantly changes;
- during the planning stages of a work site remodel or new construction;
- when two or more employees have been diagnosed with repetitive motion injuries in a 12-month period;
- when a workers' compensation request is made for an evaluation following the filing of an accident report.

Forms keep track of changes

The policy notes that a significant change in an employee's work site could involve a change of location and / or in the equipment used to perform the job. A change in job duty could involve a change in activity or in the amount of pushing, pulling, lifting, and / or carrying expected.

There are instructions on how to complete Video Display Terminal Work Site and Job Duty evaluation forms. **(See excerpt, p. 116.)**

Even though each employee workstation has been ergonomically reviewed, Tickel is looking into getting a couple of complete ergonomic work stations in which every aspect is exactly as it should be.

"We would bring these in on a test basis, for employees to try, and if they work out, we might look at getting them for all the employees," she adds. One issue that needs to be addressed, she notes, is the lack of work space on the desks. "We might move things overhead to give them more work room."

Meanwhile, reorganizing daily work tasks so an employee is not concentrating on one activity for too long can help prevent the triggering of repetitive motion problems, Tickel points out. "Maybe the employee can do some electronic billing in the morning, and then kick into follow-up [activity], making phone calls," she explains. "Then they can do more billing in the afternoon." ■

10 ways to prevent repetitive strain injury

1. Avoid prolonged sitting at a desk or computer terminal.

2. Adjust your workstation properly. Make sure your monitor is directly in front of you, with the top of the screen at eye level. Be sure your keyboard and mouse are low enough to allow you to relax your shoulders.

3. Sit up straight. Make sure your chair supports your spine in an upright position.

4. Practice proper technique. Never rest your wrists on the desk, wrist pad or armrests while you are typing or using a mouse.

5. Pace yourself. Take a five- to 10-minute break every half hour or less.

6. Get plenty of regular, vigorous exercise.

7. Do appropriate upper-body strengthening exercises.

8. Stretch frequently while at the computer.

9. Reduce time at the computer if you are experiencing pain, fatigue, or soreness.

10. Avoid using the mouse whenever possible. Use keystrokes instead.

Source: Deborah Quilter's Tips for Preventing Repetitive Stress Injuries, http://www.rsihelp.com/tips.html.

ACCESS FEEDBACK

Take creative approach in dealings with SNFs

Hospitals facing discharge delays as a result of financial restrictions on skilled nursing facilities (SNFs) are well advised to seek out their own innovative solutions, suggests **Edward Emnett**, RN, CPHQ, manager of clinical resource management at South Florida Hospital in Plant City.

As pointed out in last month's *Access Feedback* column, the SNFs are increasingly leery of accepting patients with complicated care needs because of the limited reimbursement they can expect under Medicare's new prospective payment system. With that in mind, Emnett says he is taking a proactive approach to enhancing the relationship between his hospital and the local nursing homes.

"I've gone out and done presentations on hospital discharge planning with the [skilled nursing] facility's staff, saying, 'We're in this together; we can be a team,'" he adds. "This has gotten us over some of the humps."

One issue he has addressed involves a form the state Department of Children and Families requires hospitals to complete for patients who need admission to an SNF. "The state has done audits on this in some nursing homes, and [auditors] are not amused by SNFs accepting incomplete forms," he says.

His approach to the form problem has been, "Tell me what you want and I'll try to get it." The form requires documentation from several different disciplines, which is difficult to get in a timely fashion, he points out. "We still have physicians who come in that morning and decide they want to send the patient home at noon."

As a compromise, he suggested that instead of filling in every line of the complex form — as the nursing home previously required — the hospital staff attach a copy of the patient's history and physical and current medication sheet. Answers to problems often lie in such "simple, practical stuff," he says.

Emnett sets up regular meetings with SNF administrators and arranges inservices for their staff. "This is nothing magic, just trying to go out and talk to people," he adds. "Most of us in resource management have not had to do that [before] in the community. To me, it seemed to be the only thing to do."

St. Joseph's Medical Center in Tampa, another hospital in the Baycare Health System, recently began hosting quarterly luncheon meetings with area nursing home administrators, Emnett says. "They set it up as a networking session, to deal with common problems. So far, the overall feeling has been positive."

Another idea he is pursuing is sharing hospital educational programs with nursing homes. "When we look at diagnoses, we see patterns in the readmission of patients with congestive heart failure. We're wondering if we go back and find out how many of these patients go to nursing homes, could we take the same educational program there? It might work [for both hospital and SNF] and tighten the relationship between the two." ■

Need More Information?

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AHIMA blasts Congress' failure to pass privacy bill

Representatives of the American Health Information Management Association (AHIMA), a Chicago-based association of medical record and health information management professionals, have voiced their distress over Congress' inability to meet the Aug. 21 deadline for passing confidentiality legislation.

"This is not Congress' finest hour," said AHIMA executive vice president and CEO **Linda L. Kloss**, RRA. "Still, we're encouraged by the fact that several members have introduced substantive legislation and are sincere in their desire to protect patients and their information."

Congress was on recess until Sept. 7, and a "mark-up" on Senate medical privacy legislation — in which members of the Health, Education, Labor and Pensions Committee would offer

amendments to a "chairman's mark" that combines language from three proposed bills — was not expected until after Labor Day at the earliest.

It was Congress, as part of the 1996 Health Insurance Portability and Accountability Act (HIPAA), that self-imposed the mandate to pass confidentiality legislation by Aug. 21 of this year.

According to HIPAA, if Congress missed the deadline, the U.S. Department of Health and Human Services would be required to step in and develop confidentiality regulations.

"Even though the deadline has passed, Congress is expected to continue pursuing confidentiality legislation," Kloss said. "We hope that as Congress moves forward, members will bypass the partisan issues that have been so divisive and at least pass legislation this year."

AHIMA has called for confidentiality legislation that includes these provisions:

- preemption of state confidentiality laws with a single, stringent national standard;
- the use of health information for lawful purposes only and civil and criminal penalties for breaking the law;
- the ability of patients to access their records;
- disclosure of confidentiality policies by health care organizations;
- the requirement that health care organizations have substantive information security policies in place.

Disagreement on some of those issues, as well as on whether an individual would be able to sue a party that violated his or her confidentiality, has stalled legislative progress on a bill, says **Kathleen Frawley,** JD, MS, RRA, AHIMA's vice president for legislative and public policy services. ■

Medicaid scams said to cost billions

When an unusual number of pregnant Filipino women were found to be flying to New York and California — and flying back home with newborns in tow — state officials decided to look into this suspicious baby boom. They discovered that dozens of Philippine Airlines employees were having their babies at American hospitals, with American taxpayers footing the bill via Medicaid.

Claiming to be destitute, scores of foreign visitors are coming to the United States for free Medicaid care (one Russian tourist had two liver transplants, racking up $500,000 in hospital bills). That's just one of the Medicaid scams robbing taxpayers of billions each year, *Reader's Digest* magazine reported in its August 1999 issue.

Medicaid's annual budget, slightly over $1 billion after Congress established the program in 1965, has exploded to nearly $200 billion this year. Investigators blame fraud and abuse for about 10% of that total, or almost $20 billion.

Con artists have learned how easy it is to be enrolled as a Medicaid "provider," and just how little verification claims receive before they are whisked through to payment. *Reader's Digest* blueprints some of the scams:

- **Medicaid mills.** Corrupt clinics work overtime cranking out claims for fictitious or duplicate patients. One New York City radiologist collected $1.7 million in just over two years for reviewing 24,000 unnecessary, duplicate, or phony tests delivered weekly in shopping bags by accomplices at local clinics.

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Editorial Questions

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• **Transport scams.** Driving patients to and from the doctor is a lucrative business, especially if you don't even have to start the ignition. One Florida dispatcher used her access to patient names to forge phony trip tickets, then sold them by the bundle to company cabbies. Palm Beach County Medicaid costs soared by $10 million before the ring was busted.

In California's latest scam, van drivers tote farm-worker families to Los Angeles-area clinics, where doctors use the laborers' Medicaid ID numbers to charge a variety of phony services. The drivers get a kickback; the "patients" get a meal and a pair of shoes.

To root out rip-offs, reformers told the *Reader's Digest* writer that:

• States must make better use of new computer search tools.

• More grand juries must be impaneled to target Medicaid cheats.

• Medicaid systems should send recipients and providers explanations of services paid, so honest individuals can help spot fraudulent billing.

• The Health Care Financing Administration (HCFA) should bring government agencies together to identify foreigners visiting the United States to obtain Medicaid benefits. In the past, HCFA has hindered states from collaborating with the federal government on this issue, claiming patient confidentiality was being threatened.

(Editor's note: For additional information, visit www.readersdigest.com.) ■

Transfusion of cash to save rural hospitals

A small hospital in rural southwest Georgia has received a financial shot in the arm under a new federal program that could help save many small, struggling hospitals. Southwest Georgia Regional Medical Center in Cuthbert was the first rural hospital in the state to gain federal designation as a "critical access" hospital.

The hospital will get an additional $180,000 to $200,000 in reimbursement annually from Medicare, enough to help ensure its long-term survival. The program will allow Southwest Georgia Regional to receive full reimbursement for the cost of services rendered to Medicare patients.

Usually, Medicare pays a fixed fee for each diagnosis or procedure, which is often below a hospital's costs. Southwest Georgia Regional, about 40 miles west of Albany, "has lost upward of $400,000 for the last five years," said **Keith Petersen**, chief executive officer. "This program and other things will enable us to get into the black."

Hospital survival has become an urgent issue for rural leaders after a series of Medicare and Medicaid cutbacks. Rural hospitals serve a high percentage of Medicare and Medicaid patients, along with a large load of uninsured, or nonpaying, patients and low numbers of the privately insured.

A North Carolina hospital also has won "critical access" funding, and six other rural Georgia hospitals are applying. "This is not going to solve the health care crisis in rural Georgia, but it's a piece of the puzzle," said **John Robitscher**, director of the state Office of Rural Health.

To seek the designation, rural hospitals must be publicly owned or nonprofit. In addition, a hospital can't operate more than 25 beds or keep a patient longer than four days without a waiver. Rural hospitals must partner with a larger hospital where long-term patients can be referred. It must be declared by the state a necessary rural provider. Georgia has a list of 47 such hospitals. ■