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IN THIS ISSUE

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Performance improvement team creates success in patient flow, clinician buy-in

Relentless monitoring of the discharge process is the key

A process begun four years ago when the Medical University of South Carolina (MUSC) in Charleston took a hard look at pending discharges has led to a cutting-edge bed management program and a best practice designation from two national benchmarking organizations.

Both the Oak Brook, IL-based University Hospital Consortium and the Washington, DC-based Health Care Advisory Board have recognized the hospital for "best practice for patient flow."

The basis for that achievement, explains **Maureen McDaniel**, RN, manager for bed management in the patient access services department, was a year's worth of auditing and monitoring, an active, multidisciplinary performance improvement team, and the fostering of some healthy competition among nursing units.

Key to the initiative's success, she adds, was buy-in from the hospital's physicians and nurse managers.

"Four years ago, we were having trouble getting patients in," McDaniel recalls. "There were long delays in the emergency department (ED), and we were holding patients over in outlying hospitals, so our referral business was getting a hit."

The hospital administration, meanwhile, was fielding complaints that it was taking days to get patients into the facility, she says.

Late discharges mean late admissions, notes **Cindy Williams**, manager of admissions and financial counseling, which put extra stress on her staff.

"We are staggered, so most staff are working between 9 and 5," she adds, "but we were finding some of our clinic [patients] being admitted after 5 p.m. So every hour, we were losing [an employee], but at the same time, the volume of patients was the heaviest."

To deal with the problem, Williams says, staff were staying later — increasing overtime hours — to make sure transfers were handled, and patients admitted or preadmitted, before the regular admitting office

closed at 7 p.m. After that time, she explains, the ED staff would have to get involved.

Putting the situation into context, McDaniel explains that 66% of the patients at the 568-bed hospital are unscheduled, 30% are admitted through the emergency department, and there is an occupancy rate of 88%. Sixty percent of the discharges, she adds, were happening after 3 p.m.

To address the problem, McDaniel notes, a performance improvement team was formed, with participation from nurses, administrators, physicians, housekeepers, and unit clerks. That led to the auditing and monitoring of the comings and goings of 500 patients on 10 medical/surgical units, she says, a process that was both time-consuming and labor-intensive.

"We gave a log to each of the units for monitoring when the discharge order was written by the physician, when the discharge order is taken off the chart, when the patient actually left, and when the notice of discharge was actually put in the system," McDaniel adds.

Some of the problems, she says, were that physicians were not writing orders early enough in the morning, the times for doing rounds needed to be adjusted, and the nursing units were not being compliant about putting notice of pending discharges, as well as notice of the actual discharges, into the system.

"There was a four- or five-hour lag time between when the patient left and when they notified us," McDaniel says. "Their feeling was, 'Why let bed control know we have a bed open? They'll just put another patient in it.'"

"The team knew," she says, "that we needed to build a relationship and communication with the charge nurses and unit clerks."

As the performance improvement team continued to monitor the discharge process — and let the nursing staff know they were being watched — the situation started to improve, McDaniel notes.

"I would follow through at the end of each day, go to the charge nurses, audit the discharges, make note of the discrepancies found, and send them to the nurse managers, who started using [the results] as a tool for performance evaluation, she adds. "We knew we couldn't just say, 'Hey, guys, you've got to do this.' The nurse managers had to have buy-in, their directors had to have buy-in, and when the physicians came in with buy-in, that really helped."

The physicians on the performance improvement team assisted by piloting the discharge monitoring process on certain service units, she says, with a focus on improving the situation by initiating more timely discharges.

The effort developed into a competition between nursing units, McDaniel says, with the bed control office sending nurse managers a daily list of discrepancies between the time the discharge order was written, the time the patient left, and the time the bed control office was notified.

"We would take a med/surg unit and see how many pending discharges were sent down, compared to how many patients went home that day," she notes. "If there were eight discharges, did

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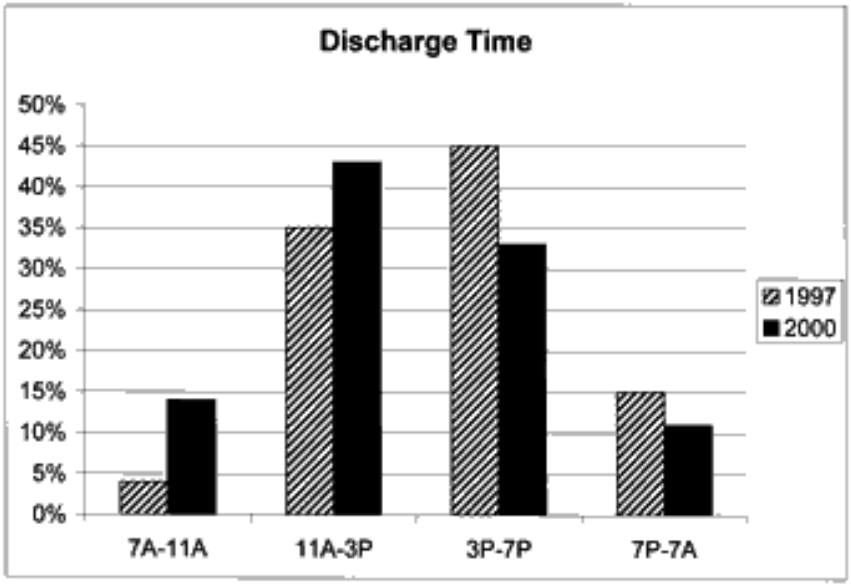
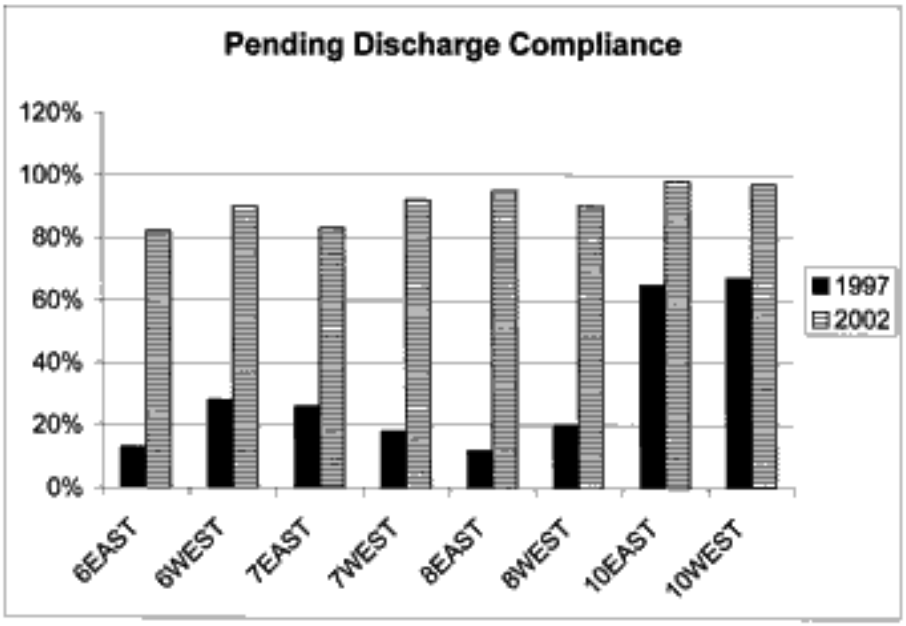




eight pendings come down?" **(See graphs, left and below.)**

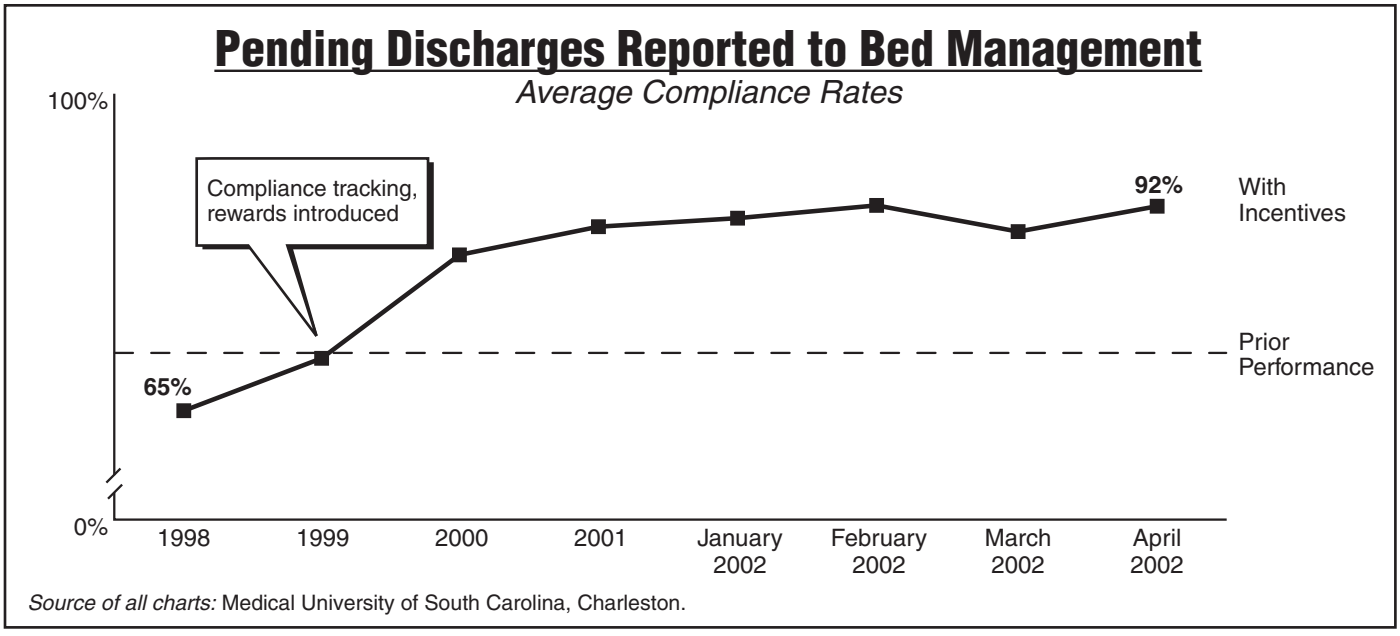
Receiving early information on pending discharges, McDaniel says, allowed bed control staff to take a proactive look at what the bed availability would be all day, and notify the ED, the recovery room, and the outlying clinics as to that status.

As the monitoring process continued, the performance improvement team decided to recognize the unit most compliant for the week, and then later, the month, she says. "When we decided to do it monthly, we would give a reward — tickets for free frozen yogurt to the entire staff of that unit — put up a big congratulations banner, and e-mail all the [hospital] directors."

To get credit, the unit nurses and clerks had to give notice of pending discharge and then follow up with the notice of discharge, she explains, with the notice given well in advance, preferably just after the physician writes the order.

"The most frustrating thing for bed control is when four or five discharges get sent down at once," McDaniel adds. "You know a bus didn't come and pick everybody up."

Over time, she says, there has been a shift in discharge times, so that 46%



Source of all charts: Medical University of South Carolina, Charleston.

Adding admission nurses enhances bed placement

Effect on customer service 'remarkable'

With nursing units swamped in the afternoon with unscheduled admissions, nurses at the Medical University of South Carolina in Charleston were complaining about the arduous database they had to complete on admission of each patient, notes **Maureen McDaniel**, RN, manager, bed management, in the patient access services department.

"[Nurses] do an initial database for all patients coming through the emergency department (ED) and from the clinics," she explains. "The database has grown in size because there's an inordinate amount of tracking done now. Nurses were complaining that it takes too long to admit a patient."

That issue was contributing to the general reluctance nurses felt at the idea of quickly turning over beds and bringing more patients — and paperwork — onto the unit, McDaniel says.

"The director of nursing approached me about managing a couple of nurses who would complete the data base," she adds. "The director and I both agreed that patient access was the place for these nurses, since bed placement starts in our shop."

The two admitting nurses are located in the bed control office, and they do hourly checks of the unscheduled admissions.

What was started as a trial, however, with the goal of boosting morale and creating a nurse retention tool, has become much more than that, says McDaniel.

"[The admitting nurses] have made a big impression with patients," she notes. "It's something you can't measure in dollars and cents, but the customer service piece is remarkable."

In addition to the database duties, McDaniel says, the admitting nurse makes sure the phone works and the patient's dentures are put away, and explains how the security lockup works. "She is the first person the patient or family member sees."

One admitting nurse works 11 a.m. to 7 p.m.; and the other, noon to 8 p.m., she adds, because unscheduled admissions typically begin after 11.

The day after an admission, McDaniel says, the admitting nurses go back into the computer system to make sure the demographic information for those patients is accurate, comparing the data they gathered with what the registrar has put in.

"They make sure everybody has their advance directives, and if they see anything wrong in the demographics, they take it to the registration staff and change it," she adds. "They also give patients the cafeteria hours, parking information, and a map of the hospital, and leave e-mails for the physical therapist and the nutritionist."

"It's a nice hotel kind of thing." ■

of patients — rather than 60% — leave after 3 p.m. "It's a slight shift, but enough so there are not as many patients waiting."

From the admitting office perspective, Williams notes, understanding early in the day what the discharge activity will be has enabled her staff to get patients preregistered and admitted closer to 3 p.m.

Overtime no longer is an issue, she says. "Staff come in and work their shifts. If a patient doesn't arrive by 5 p.m., [the admission] just requires activation, because the person is already pre-admitted."

As an additional benefit, McDaniel says, "there is so much more communication between the bed control office and the charge nurses."

Day starts with 'bed meeting'

To keep that communication ongoing and active, she says, McDaniel in the past year has instituted bed meetings in three different locations.

At 8:30 a.m., McDaniel explains, she or one of the nurses on the bed control staff, goes to a meeting at the pediatrics hospital that includes case managers, the charge nurses of each unit, and social workers. "Bed control brings the elective admissions list to the table, and [the other participants] bring a list of patients they think are going home."

"We make bed assignments," she adds, "based on the bed availability at that time, for scheduled admissions and any transfers from the intensive care unit [ICU]."

Because she knew nurses would be reluctant to have a meeting scheduled during their busy morning time, McDaniel notes, she promised to keep it short and sweet.

"We just do what we need to do, and we keep it to 15 minutes," she says.

As an added incentive, she sends a monthly report card to nurse managers, letting them know the attendance record of the charge nurses.

A similar meeting is then held in the lounge of the med/surg unit, and at 9 a.m., the process takes place in the ICU lounge, she says. "We talk to them about any patients coming to them off the operating room schedule and any who need

to come out of the units."

By the time she gets back to her office at about 9:15 a.m., McDaniel says she has a pretty good idea of what the day will look like.

"What these meetings have achieved over a year's time is that everybody starts the day knowing what the hospital is about," she adds. "It makes them so much more global, and they're enjoying that. They don't have that 'silo' feeling."

(Editor's note: Maureen McDaniel can be reached at mcdaniem@musc.edu.) ■

Data quality review 'one of best around'

Every outpatient registration is checked

Not only do the verification and quality services personnel at North Carolina Baptist Hospital in Winston-Salem perform one of the most thorough registration quality checks around, they've been doing it for 12 years.

When **Keith Weatherman**, CAM, assumed his position there as associate director of patient finance, he was pleasantly surprised to discover the data quality review process was "the best I'd ever heard of."

"It seems like there is still finger-pointing [at registration] going on at other places I hear about, but here the front end is pretty well covered," he adds. "We just don't hear the fussing from the back end that happens at other hospitals."

Weatherman credits **Darlene Caudle**, manager of the verification and quality services department, and supervisor **Teresa Colvert**, who does all the departmental training and directly oversees the quality review staff. Both have been with the department since it was created.

"At the time," explains Caudle, "I was working in the collections department, cleaning up errors that occurred at registration and all the way through. I suggested it would be good to have a department to review registrations and get those errors corrected before the account was billed."

At first the department included two groups of employees — the quality review group (for outpatient registrations) and the verification group, which verified insurance and benefits for inpatients, outpatient surgery and the 24-hour observation unit, adds Colvert. "It was Darlene, myself, and 17 employees."

Several years later, a preadmission function was added, along with 10 new employees and a second shift," she notes. "[Preadmission counselors] would call patients who were scheduled for admission, outpatient surgery, or a procedure in our day hospital. They would make calls until 9 p.m."

A few years later, Colvert says, a pre-certification group, made up of nurses formerly with the hospital's utilization review department, joined the mix. "Now we have nurses who get pre-certs started with patients who are going to be admitted or have outpatient procedures, she adds. "So we've gone from 19 people to about 42 people."

Colvert has trained all new employees since department's inception, she says, with some help from the quality review group. The reviewers show new employees how to use the Blue Cross Blue Shield network, known as Blue E, and the Medicaid common working file to verify eligibility.

Sometimes, she says, the new hires sit with quality reviewers so they can better appreciate the importance of registration accuracy.

Two years ago, Colvert notes, she acquired a training assistant who helps out about once a month and otherwise works as a financial counselor.

Conversations with access colleagues at other hospitals indicate that "a lot are talking about but not many are doing" the kind of extensive quality review that Caudle and Colvert oversee, Weatherman notes. "It's a good tool to show where employees stand and where they might need more training."

Unlike at many facilities, where random quality checks are conducted, quality reviewers at Baptist Hospital check every outpatient registration. Inpatient registrations do not go through the same process, Caudle says, because financial counselors verify that information in advance.

Registration report is key

The basis of the quality review is the registration report, which is a single sheet of paper for every registration done the day before, Colvert adds. "The front side has the demographics and the physician information, and the back side has the insurance information."

On a daily basis, Caudle explains, the quality review process works as follows:

1. Sheets are gathered from all outpatient registration areas, including the emergency department,

outpatient clinics, and private outpatient areas (tests and other diagnostic procedures).

2. One of the reviewers — typically the same person — divides the sheets among those on duty that day. Each reviewer's name is put on a board, along with the sheets that person has been assigned. If a reviewer doesn't finish that day's sheets, because of illness or reports that take extra calls to insurance companies. "Everyone pitches in and helps, so that everyone stays together. The team atmosphere keeps the whole group moving along," Caudle adds.

3. Reviewers examine each work sheet, which is "a picture of the registration as it is in the computer," looking closely at 19 key data elements, including name, telephone number, next of kin, accident screen, and insurance information. "We look closely at family and referring physicians because we're very interested in tracking that at our facility," Caudle notes;

4. Errors are highlighted in yellow or pink.

"Yellow [indicates] a critical area that would cause a problem with reimbursement," she says, "such as an ID number, policy holder, or insurance address." Errors highlighted in pink are considered less serious, Caudle adds, and are either sent directly to the individual registrar for correction, or in some cases, to the registration manager, who distributes them to the registrars in that area.

Because of reimbursement concerns, reviewers correct the more critical errors to ensure a clean claim is sent to payers, she says. "The bill goes out in five days, regardless of what we do."

During the highlighting process, Colvert explains, quality reviewers call insurance companies as necessary, and use the electronic tools like Blue E and the common working file to check the data.

"Before they send the highlighted sheets back [to the registrars], they access a weekly Excel spreadsheet, which has a separate file for each department we review," she notes. "Within each file, there are separate folders for each [registrar] in that department."

Each day, reviewers pull up the folders of all the registrars whose work they have checked and load the resulting figures, or scores, into the spreadsheet, Colvert says. "They compute a maximum potential for that [registrar] — the possible number of data elements they could have gotten correct in that work, and then subtract the errors to come up with the number achieved."

On a weekly basis, the computer calculates a demographic achievement rate, an insurance achievement rate, and an overall achievement rate for each registrar, she adds.

From the spreadsheets, Colvert says, she creates her part of the report, an achievement summary that is given to all registration managers. "It includes all the [registrars] in their department, and shows the number of registrations reviewed for that person that week, the total maximum potential for that week, the number achieved and the achievement rate. [Figures] also are totaled for the entire department."

Managers get a packet containing the departmental report and individual reports, which are distributed to the registrars, she adds. In most of the affected departments, Colvert says, the quality review results are used in employees' annual evaluations. Registrars who maintain an accuracy rate of 99% over a six-week period receive a special benefit, Caudle notes. Their work is given a cursory look, but no longer is reviewed like that of their peers.

"Every quarter or so we pull [a sheet] to make sure they maintain [the quality level]," she says. "If they don't maintain it, we take away the exemption; but most work hard to maintain." The managers in their departments also recognize these registrars for their achievement, Caudle adds.

"It's quite amazing, but the big majority of [registrars] are quite conscientious about this," she says. "I'm often asked the question, 'Doesn't [the process] cause morale problems or negative interaction?' It has not had that effect. We try to show everything in a positive light and make certain they understand the importance of the role they play, and that if it's not right, we don't get paid."

Using phrases such as "maximum potential" and "achievement summary" in the review process was a very deliberate choice, Caudle points out. "We are very careful to keep it on a positive note, not a negative one, and we've gotten good feedback from the [registrars]."

To help ensure consistency, she says, "every 90 days or so, we take the same [registration] sheet and give it to each quality reviewer. Then we look at the sheets to make sure they're verifying in the same way."

If registrars disagree with a mark made by the reviewer, they can take their complaint to a manager and, if the issue is not resolved there, send the sheet back, Caudle explains. "Usually, Teresa and I look at those sheets and, if it's appropriate, we adjust the person's score. Either way, we

always give feedback."

"If we see that particular [registrars] are having problems keeping their scores up," she adds, "we ask the manager to send the person back for some additional training." Less often, Caudle says, she, Colvert, or the financial counselor/training assistant will work one on one with registrars in the individual departments.

Caudle has been working part time in the ED registration area, she notes, not only because staffing is short, but also to see firsthand how registrars are doing. "It allows them to use me if they have questions, and for me to see if they were properly trained."

[Editor's note: Keith Weatherman may be reached at (336) 713-4748 or at kweather@wfubmc.edu. Darlene Caudle may be reached at (336) 716-0720. Teresa Colvert may be reached at (336) 716-0721.] ■

ACCESS FEEDBACK

Space redesign, counseling boost ED collection efforts

Before, charts were walking out the door

When **Tara Tinsley**, CHAM, began working as an access supervisor in the emergency department (ED) at Children's Health Center in Birmingham, AL, registrars weren't asking for copays, and were collecting only about 10% of the dollars that could have been collected up front.

"When I first got here, we may have been collecting $5,000 in a month, and we probably see 5,000 patients in that time, so that's not a lot."

In addition, says Tinsley, who also is department trainer, "we had a considerable amount of patients who would actually leave with their charts" without being discharged.

She shared her experience with *Hospital Access Management* in response to a request for information on ED cash collection practices in the May 2003 issue by Lori Judge, MS, HAS, director of patient financial services at St. Claire Regional Medical Center in Morehead, KY.

The 26-bed treatment area wasn't far from a handy exit, Tinsley continues, and with three nurses releasing patients at the same time, it was easy for patients to elude the checkout process. "The nurses are so busy," she adds, "and they don't have ownership with the clerical piece [of the process]."

One of the things she — along with the ED supervisor for the second and third shifts — pushed for from the start, Tinsley says, "was a means to increase our visibility to the nurses as well as the patients, to minimize the number of charts that walked out."

"We needed to have discharge more controlled and closer to the nursing staff, so we moved that area to the back, inside the ED," she notes. "We had instant improvement with visibility, as well as a decrease in the number of charts leaving."

The increase in collections wasn't quite as immediate, Tinsley says. "It took a while to train our community that we would ask for copays. It just took repeated efforts, just getting [registrars] in the habit of saying, 'Your copay is X amount. How would you like to take care of it?'"

Registrars then inform patients of the methods of payment that are available, she adds. "If the patient says [he or she] can't pay, or didn't have to pay last time, they just repeat [the information] and say, 'Next time, keep that in mind.'" Sometimes patients can't pay the full copay, Tinsley says, and the hospital will accept a partial payment. Four years later, she notes, ED cash collections are up to between $25,000 and $30,000 a month.

MSE requirement is strict

Many hospitals define a medical screening exam (MSE) — for purposes of the Emergency Medical Treatment and Labor Act (EMTALA) — as what happens at the point of triage, Tinsley notes. That means that after triage, registrars at those facilities are able to talk with patients about payment, she adds.

The process at Children's Health is more restrictive, she points out. "Our MSE is when the physician has gone in and started seeing the patient. So our patients are triaged, and then registered with general information."

However, Tinsley notes, a software program that runs within the registration pathway allows registrars to verify benefits in real time. We get the insurance card and make copies, but we don't discuss payment."

Once that initial registration is completed, she

says, "we let the nurses know and they proceed with secondary assessment or other treatment."

If a patient is flagged as self-pay during the initial registration, Tinsley says, one of the hospital's two financial counselors goes into the treatment room after the physician has been in. "They wait and watch the tracking board to see when [the physician] has gone into the room."

Counselors make the difference

The counselors — who work from 8 a.m. to midnight — talk to patients about the programs for which they may qualify, determine their ability to pay, and provide applications for those programs if appropriate, she notes. That piece of the process has been in place about 3½ years, Tinsley adds.

The big advantage of having counselors in the ED, she points out, is that more patients can be certified for financial help immediately, and without wasting time applying for the wrong program. In some cases, Tinsley notes, the counselors find that the person does have coverage, but just didn't bring an insurance card.

For patients who receive treatment on weekends, Tinsley adds, financial counselors follow up by telephone and the process typically is completed within three days.

"Without the financial counselors, [uninsured patients] would be sent a self-pay bill, and then the full bill cycle of a month or more would run," she says, before the patient would be identified as a candidate for financial aid.

Financial counselors have guidelines showing whether patients would qualify for Medicaid, or for the less restrictive All Kids, an Alabama initiative for children whose parents' income level places them just short of qualifying for Medicaid, Tinsley explains.

"During counseling, they tell the patients which program they're applying for, she says. "A lot of times we have people thinking they should try Medicaid, but [if they don't meet guidelines], that just delays their getting help."

Young patients can be certified immediately for the Jefferson County Program for Uninsured Children, she notes. If they later qualify for Medicaid assistance, that coverage is retroactive, allowing the county program to be reimbursed.

As for Judge's speculation that investing in financial counselors in the ED would pay off, Tinsley says her experience confirms that.

"[Financial counselors] definitely help," she says. "They identify things that are not usually found out until after the bill has dropped. Our bills drop within five days, so they're doing all this within five days. Without them, we would have more accounts receivable days."

[Editor's note: If you have feedback on this issue, or comments or information to share regarding any access topic, please contact editor Lila Moore at (520) 299-8730.] ■

Access preparations pay off when disaster strikes

'Everybody was there, ready and waiting'

When an explosion happened at a nearby bean processing plant, the good news was that Mercy Medical Center in Sioux City, IA, was ready to handle the eight injured workers brought in for treatment.

"It seemed to go smoothly," says **Gail Schoenrock**, patient access services manager. "There are people all over the hospital whose responsibility is to show up [in a disaster situation], and everybody was there, ready and waiting, as the ambulances pulled up. Everybody knew their job."

The disaster was "called" about 9 a.m., she adds, and the night registrar in the patient access department — who was working a couple of hours past her normal shift because of other staffing issues — stayed at her post. Other employees — those who had the day off or were scheduled to come in later — were called in, Schoenrock notes.

She went to the emergency department, where she readied the downtime slips — system-generated account numbers — that are used when the computer system is down or in the event of a disaster, when patients' demographic information cannot be determined immediately.

"To get started, to give care," Schoenrock adds, "we use the downtime [account] numbers so tests can be ordered. As the family arrives, or whatever, we get more of the demographics and insurance [information]."

One of the things that was apparent right away, she notes, was that two people were needed at the disaster command post, with one doing all the registration.

"It doesn't work to have more than one person registering," Schoenrock says. "It gets too confusing. And you need one person answering the phone so the [registrar] doesn't have to stop and answer."

In this case, she filled the second role, Schoenrock says, which also included coordinating room assignments with bed control staff, and handling people who came to the registration window.

People who were connected with the disaster situation were escorted back to a family waiting room, she says. "Otherwise, there were people at the door directing [nondisaster cases] to a separate registration booth and separate triage area."

In addition, Schoenrock notes, she distributed photocopies of explosion victims' face sheets to the ambulance companies, and provided information to law enforcement officials.

Copies of face sheets and downtime slips were placed in a "disaster basket" for the hospital administrative staff, she adds. "They came in to get those so they could keep track of who's here, in case they need to do a news briefing, or if family members call." ■

Hospital operation is smooth during blackout

But event sparked look at IS location

It was pretty close to business as usual for New York Presbyterian Hospital during the electrical blackout that hit a large swath of the northeastern United States in August 2003, but with one important realization gained, says **Bill Greene**, vice president for professional services.

From the public's perception, he notes, registration and other processes proceeded normally, except that lights were dimmed to save generator power and elective surgeries were canceled.

"I was incident commander, and we had a flawless event," Green adds. "We treated it as an internal disaster, and we were on generator power, with all of our patient care and treatment areas on full power."

But he says the incident caused him to seriously question the location of the organization's information systems (IS) department blocks away from the main hospital campus.

"One interesting nuance is that we're at 68th Street and East River, and our server farm is at 38th Street in Midtown," he says. "[The IS department] has a backup generator of course, but the logistics in convincing the diesel fuel tankers that they had to give priority delivery in Midtown were interesting, because they were [giving priority] to hospitals."

Greene says he was able to explain the situation to those in charge of fuel distribution so that the IS department's generator kept going, but there was a lag time between when the hospital regained normal power and when the server farm was back on line.

"The hospital itself obtained full power at about 2 in the afternoon, but lower Manhattan didn't have it until 7 or 8 at night," he adds, because the power company was doing a progressive rollout of service.

As a result of the blackout, Greene says, "I was looking through the retrospective scope and questioning the wisdom of putting the IS department some 30 blocks away and whether we would be better served for it to be on our campus powered by our generators."

During the emergency situation, he points out, the hospital's IS department was the only occupant of the commercial building in which it is located. "I'm concerned about keeping service up and running, and also about 50 of our employees in an otherwise unoccupied building."

"I am strongly advocating the relocation of the IS department back to the main campus of the hospital," Greene adds.

As for the other parts of the blackout scenario, he notes, "this was just one of those things that happened, and we didn't lose a bit of patient data or of functionality. We were up and operational throughout." ■

'Reasonable' registration still guideline for CMS

But what exactly does that mean?

New regulations regarding the Emergency Medical Treatment and Labor Act (EMTALA) notwithstanding, patient access managers continue to seek clarity on exactly how much registration activity may take place in the emergency department (ED) before a patient's treatment is completed.

One common concern has to do with whether, and if so, to what extent, registrars can proceed with information gathering after a nurse triages the patient — getting a brief history, vital signs, doing a cursory assessment and categorizing the condition as emergent, urgent, or nonurgent — and the person is placed in a treatment room or

returned to the waiting area to await space.

According to **Stephen A. Frew**, JD, a longtime specialist in EMTALA compliance, the comments associated with the new regulations emphasize that the Centers for Medicare & Medicaid Services (CMS) remains committed to the Office of the Inspector General's (OIG) advisory that allows "reasonable" registration, forbids prior authorization, and forbids practices that raise financial barriers before the completion of the medical screening examination (MSE).

The full text of the OIG position is found at Frew's web site, www.medlaw.com/oig.pdf.

Best practices?

Although the OIG position refers to "best practices," says Frew, a risk management consultant for Physicians Insurance Co. of Wisconsin in Madison, these descriptions should not be construed as being merely suggestions. The so-called best practices, he notes, have been applied as the site review standard in past visits.

His experience with citations issued before and after the OIG regulations and guidelines, Frew notes, is that they are enforced as follows:

1. Before triage, the hospital may obtain the patient's name and one identifier — date of birth, address, or Social Security number, etc. If a clerk (registrar) takes this information, he or she must have no discretion in assessing the severity of the situation, and all patients must be presented to triage as quickly as possible Allowing any discretion on the part of a clerk, security guard, etc., as to whether the patient is to go to triage or register first is likely to generate a violation, he emphasizes.

2. Triage is provided following the triage protocol adopted by the hospital.

3. The patient is triaged directly to the treatment room or to the waiting area.

4. Waiting area patients may be registered to the extent of basic demographic information and may be asked if they have insurance. If so, Frew says, it is OK to copy the insurance card or get the name of the company, but the process must not delay care or put any financial pressure on the patient. Registrars may *not* discuss insurance coverage by saying, for example, "We will see you, but did you know your insurance does not pay here," or "Have you contacted your insurance company to get permission to be here?" Additionally, he says, registrars may *not* contact the insurance company for preauthorization or confirmation of coverage at this point. This includes public aid, Frew points out, regardless of any agency rule to the contrary.

5. If the patient goes directly back to the treatment area because of acuity, registration should wait until the MSE has been completed and stabilizing care has been started. Obtaining information or financial guarantees, and nonessential inquiries should be deferred until that point, he says, and that applies to questions to family members, as well as to the patient. Financial pressure on the family is just as likely to influence care, Frew points out, and also is likely to generate the financial discrimination complaints that lead to investigations and citations.

6. CMS may allow treatment authorization calls to be made following the MSE and while admission and surgery or other stabilizing care is being arranged or delivered, but the care must be rendered regardless of what the insurance company, gatekeeper physician, or agency says. Since most insurance allows reports within 24-72 hours of a visit, he notes, there is no good purpose for making an immediate call. Once an insurance denial is in the record, Frew says, it casts a pall of cynicism across all subsequent care decisions. If such calls are made, or if financial information is automatically called up by the computer system from past visits, it is best to separate the face sheet from the patient care chart, so that clinical decisions cannot be influenced by the information.

7. Once the full MSE has been completed, the decision to either admit or discharge the patient has been made, and the disposition of the case has been entered in the record, it is generally safe to get full financial data prior to discharge or as an element of admission. If a patient raises questions about financial coverage, Frew says, the OIG suggests those questions be deferred until after the MSE, or if the patient insists, that a financial counselor trained in EMTALA requirements be available. Some hospitals have such patients sign a waiver saying it is their choice to have that discussion before necessary care, he notes.

Frew cautions that CMS will take the patient's version of a discussion unless it is fully documented to support the hospital. He recommends that physicians and nurses never discuss financial issues with patients.

The bottom line, Frew indicates, is that even if what you do actually produces no delays in care, that's not good enough. CMS looks at whether your system has the *potential* to delay patients or put financial pressure on patients. ■

NEWS BRIEFS

Legal concerns addressed regarding JCAHO review

The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has announced two options intended to mitigate legal concerns related to the periodic performance review component of its new accreditation process.

An organization can opt to attest that it has performed the midcycle self-assessment, completed a plan of action to address areas of noncompliance and identified measures of success for validating resolution of the identified problem, JCAHO said.

In that case, the organization would provide its measures of success to JCAHO for assessment at the time of the complete on-site survey.

Alternatively, JCAHO said an organization need not conduct a midcycle self-assessment and develop a plan of action, but for a fee could undergo an on-site survey at the midpoint of its accreditation cycle. The organization would develop and submit a plan of action to address any areas of noncompliance found during the on-site survey, and provide its measures of success to JCAHO at the time of the complete on-site survey.

More information is available at www.jcaho.org. For a more complete discussion of the new JCAHO survey process, see the June 2003 issue of *Hospital Access Management.* ▼

Medicaid spending slows, first time in seven years

Medicaid spending growth slowed in 2003 for the first time in seven years as all 50 states implemented Medicaid cost control strategies, according to the latest survey by the Kaiser Commission on Medicaid and the Uninsured.

Average spending growth for Medicaid in 2003 was 9.3%, down from 12.8% in 2002, the survey indicates.

Over the past three years, all 50 states have taken action to control drug costs and reduce or freeze provider payments, while 35 states have reduced benefits, 34 have reduced or restricted eligibility, and 32 have increased Medicaid copayments, the survey found. Inpatient hospital rates were cut or frozen in 31 states in fiscal year 2003. Ten states planned to reduce hospital payment rates in fiscal year 2004, while 22 states planned to freeze rates.

While spending on Medicaid has slowed, enrollment in the Medicaid program increased 7.8% in FY 2003 and is projected to increase 5.3% in FY 2004, another report released by the commission indicates. The report largely attributes the recent surge in Medicaid enrollment to the economic downturn, which has resulted in declining incomes and lower rates of employer-sponsored insurance among low-income Americans. More on the reports is available at www.kff.org. ▼

EMTALA sourcebook cuts through new regs

You and your facility waited more than a year for the final revisions to the Emergency Medical Treatment and Labor Act (EMTALA), but are they really good news?

Emergency department (ED) managers and practitioners, hospital administrators, risk managers, and others must quickly digest this complex regulation and determine how the changes will affect patient care. The revised regulation takes effect Nov. 10.

EMTALA: The Essential Guide to Compliance from Thomson American Health Consultants, publisher of *Emergency Medicine Reports, ED Management, ED Legal Letter,* and *Hospital Risk Management*, explains how the changes to EMTALA will affect EDs and off-campus clinics.

COMING IN FUTURE MONTHS

- AMs share training techniques
- Tips on handling ABNs
- HIPAA's security rule explained
- One person's access career path
- Innovative customer service strategies

Key differences between the "old" EMTALA and the new changes are succinctly explained.

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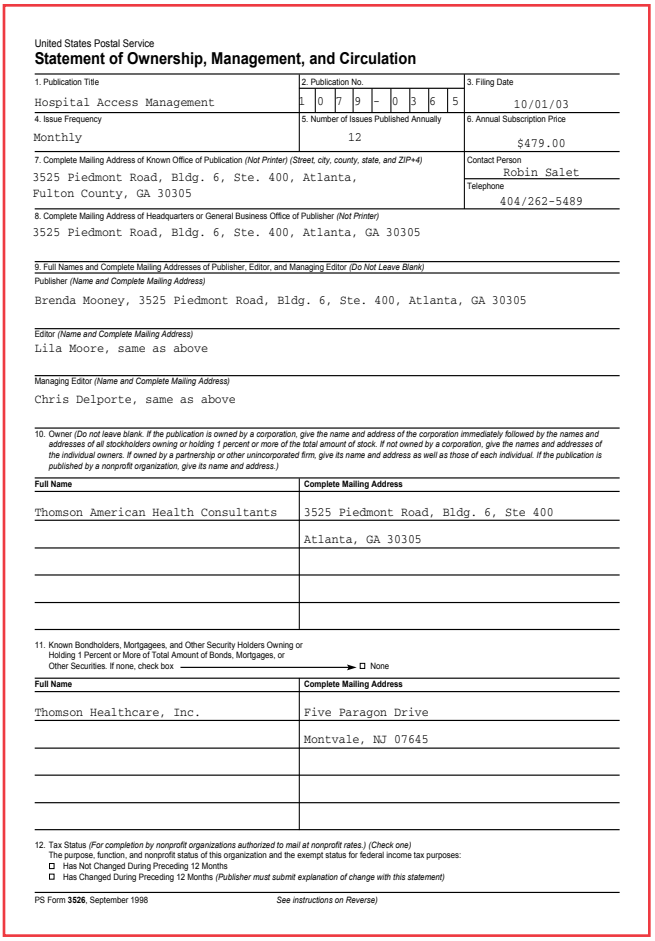
- Do the revisions mean hospitals are less likely to be sued under EMTALA?
- How does EMTALA apply during a disaster?
- What are the new requirements for maintaining on-call lists?
- How does EMTALA apply to inpatients admitted through the ED?
- What are the rules concerning off-campus clinics?

Edited by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency Medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine, Peoria, *EMTALA: The Essential Guide to Compliance* draws on the knowledge and experience of physicians, nurses, ED managers, medicolegal experts, and risk managers to cover the EMTALA topics and questions that are most important to you, your staff, and your facility.

EMTALA: The Essential Guide to Compliance provides 18 AMA Category I CME credits and 18 nursing contact hours. To order your copy today for the special price of $249, call (800) 688-2421 and receive this valuable guide to the new EMTALA. ■



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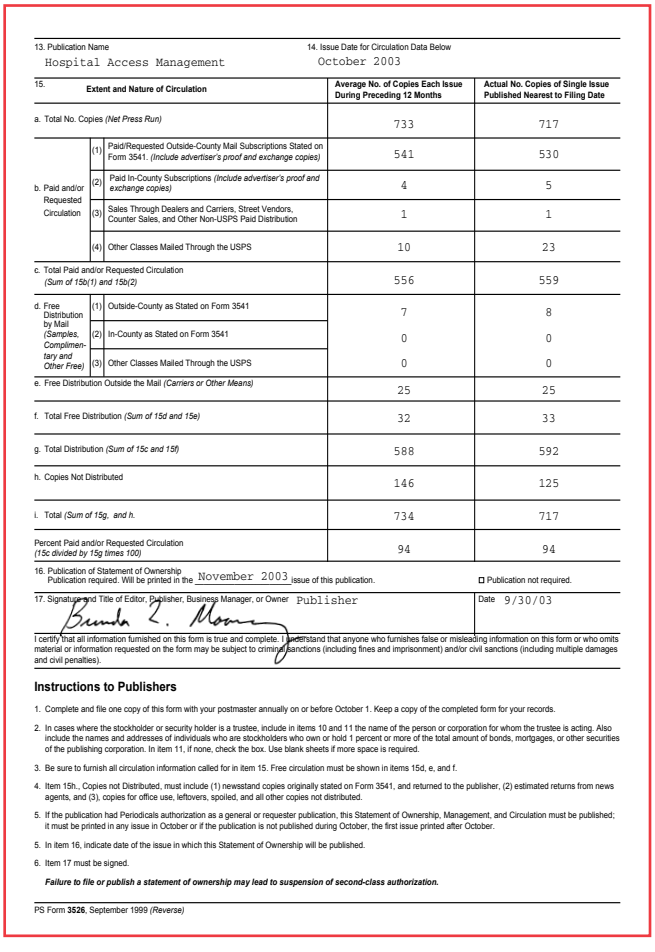

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Latest hiring trend adds medical records experience to access mix

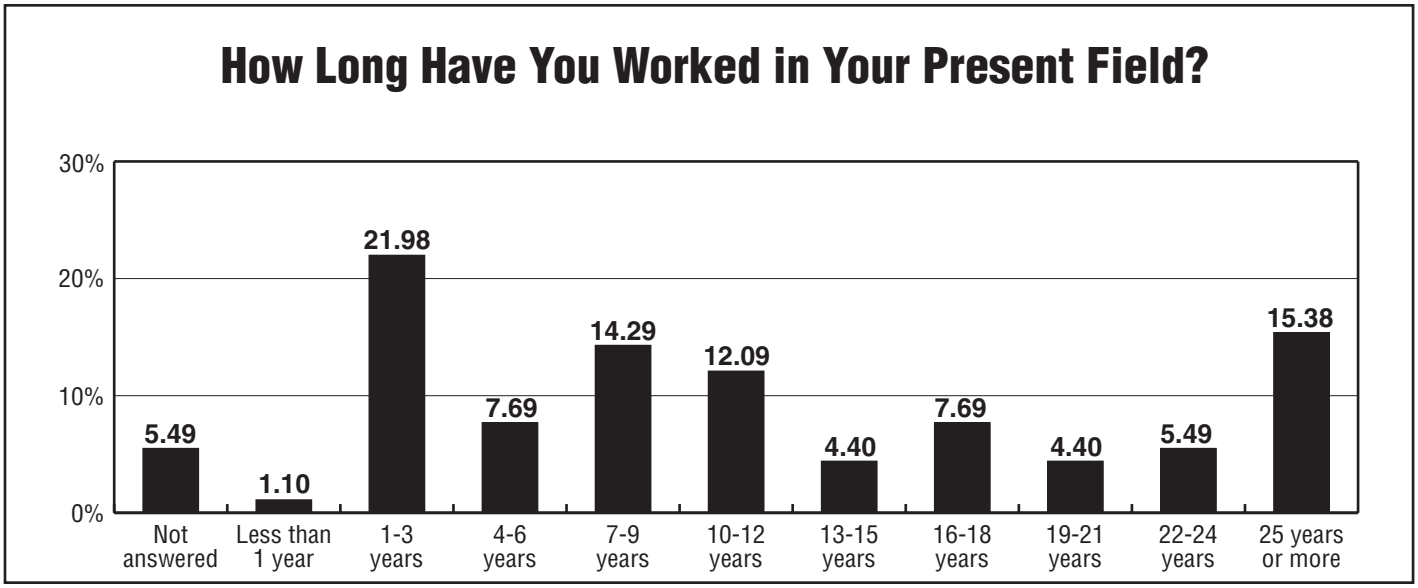
Hospital requirements more demanding, but salaries not always in line

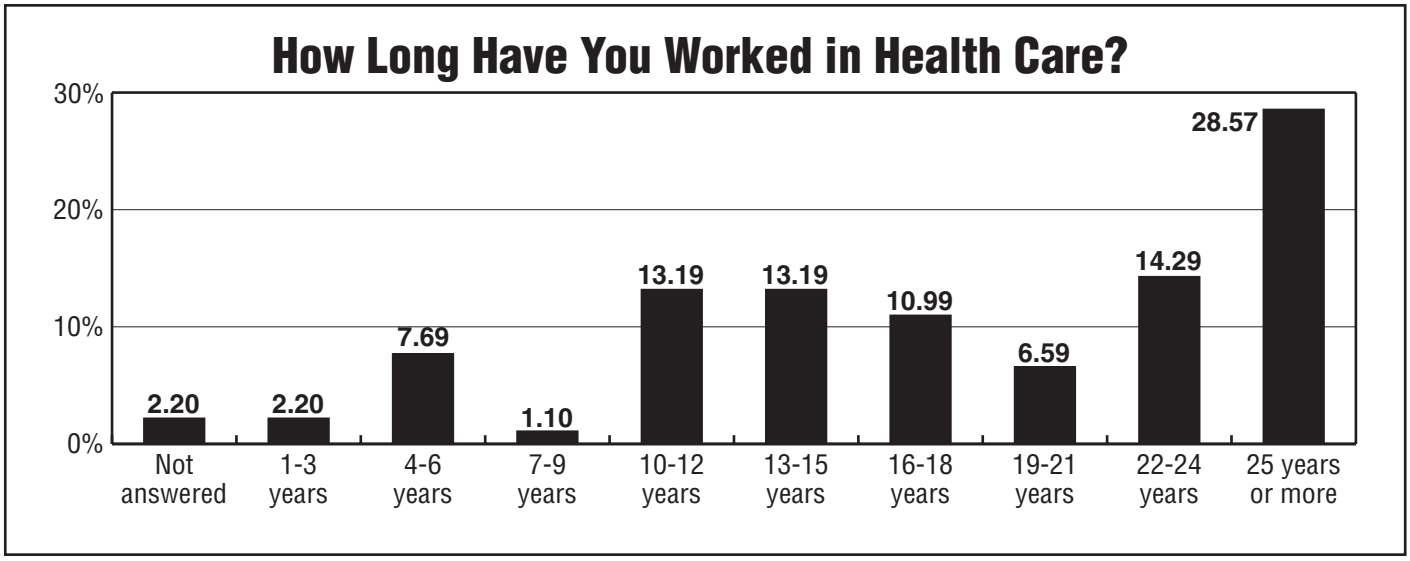
It's been clear for a while that patient access managers could increase their marketability by beefing up their business office and patient accounting experience. But the very latest trend appears to be toward hiring a triple threat — someone who also has a background in medical records.

A bachelor's degree in health information management, along with certification in the field, can help push an access manager's salary prospects into the six figures, depending on geographical location, says **Gina Seewald**, executive recruiter for Atlanta-based Lillian Klock & Associates.

"There seems to be a trend starting where it's desirable [to hire] someone who has a background in medical records as a director, to oversee not only medical records, but patient access and the business office, she adds. "Six figures is very possible, but salaries are influenced by geographic location."

In less urban, low-paying areas, the salary for a person with those credentials might be $70,000, Seewald estimates, while in an area





"where demographics and lifestyle [costs] are higher, you're looking at a range of $110,000 to $120,000."

Another trend she has noticed is that hospitals are giving more weight to academic degrees. While in the past, 10 years of experience might have gotten the job, now it is more likely to be two years of experience with a degree.

Depth of knowledge regarding various kinds of patient access software is "very valuable," Seewald adds.

While the medical records piece still is a small blip on the radar screen for access director positions, she indicates, there is no question that "there are definitely more opportunities and it's more desirable to have a business office background."

Gaining respect

As has been the case for several years, Seewald says, the field of access services continues to gain more respect. "Finally, it's recognized that what happens on the front end really affects the back end. There seems to be even more focus on quality assurance, streamlining, and making sure the business office and the access office are hand in glove, that there is a meeting of the minds."

Scott Johnson, senior vice president and partner in J&J Resources, a health care placement firm based in Houston, agrees that hospitals and health systems are increasingly aware of the contribution a good access director can make to an organization's financial well being.

But he says, in many cases, the salaries being offered aren't matching the qualifications being sought.

"There have been numerous jobs for patient access directors I've tried to fill, but what I'm seeing is a lot of hospitals don't want to pay what it's going to take," Johnson says. "That's what is discouraging about it. You'd think an individual who has shown what they've done, how they've saved money, who can increase the bottom line, would be worth another $4,000 or $5,000 in salary. They can make that up in no time."

He says he recently placed someone in an access director position at a 355-bed hospital in the Carolinas, with a salary in the upper 60s.

"She was coming from a salary that was about the same," Johnson recalls, "but it was a situation where she had to get out because of instability, which is why they got her for [that amount].

Just recently, he adds, he was trying to fill a regional access director position on the East Coast that would include oversight of four or five hospitals. "They wanted to top out at $70,000 or $80,000."

"I worked on the search," Johnson says, "but wasn't able to get anybody for them. You've got people running [access departments] at 300- or 400-bed hospitals making that."

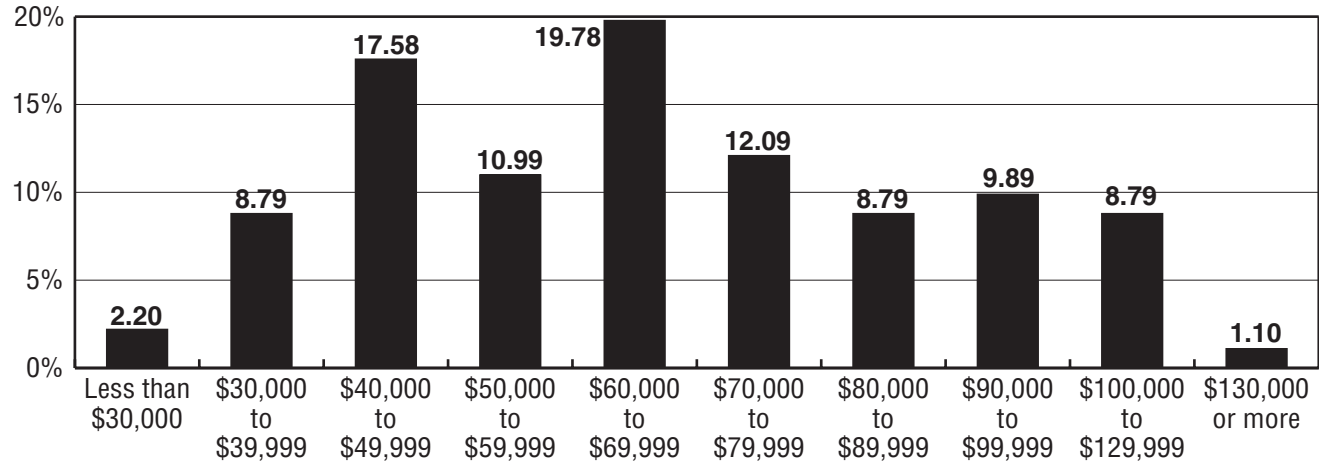
About 20% of his firm's business involves patient access directors, Johnson says, and in recent months those positions have been more difficult to fill. "Money's been an issue on just about every [placement]. [Hospitals] want the world — they're really picky — but the salaries aren't matching what they want."

Playing politics

"Salary politics" may play a role in hospitals' reluctance to offer more equitable salaries for

(Continued on page 4)

What is Your Annual Gross Income from Your Primary Health Care Position?



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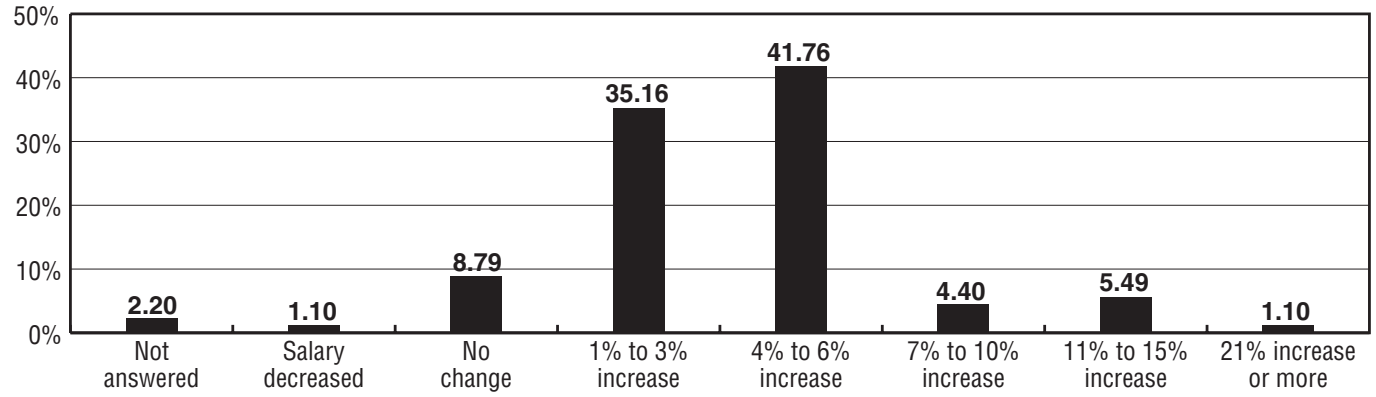
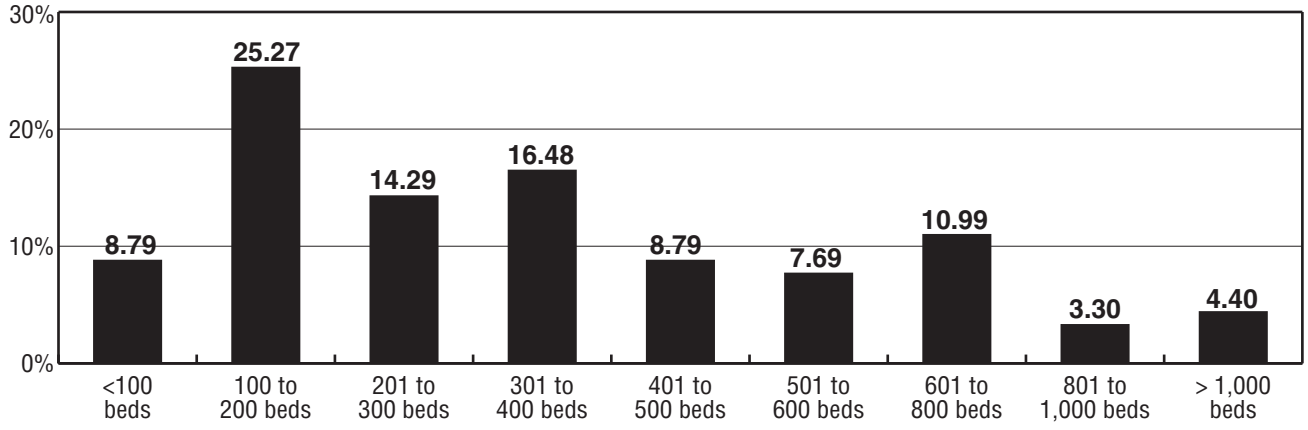


If You Work in a Hospital, What is Its Size?



access professionals, he adds. "It's the idea, 'If I pay this person that amount, I have to go around and give all the directors more money."

Adding to the difficulty in placing access directors, Johnson points out, is the fact that the field is dominated by women, who traditionally have been less willing to uproot family in order to make a move. That's particularly true, of course, if the salary increase being offered is not significant, he notes.

Still, there are hospitals that are willing to pay salaries that are in line with the skills they're demanding, Johnson says.

"We've got a hospital here in Texas with 800 beds or so that's doing a search for a patient access director. They're actually stepping up to the plate and are going to pay $90,000."

Salary breakdown

Most hospitals won't pay recruiters to fill manager-level access positions, he notes. "They typically promote a supervisor from within unless it's a huge organization. Even then, they've always got three or four supervisors eager to move up."

The biggest percentage of access professionals responding to *Hospital Access Management's* annual salary survey — some 20% — reported having salaries of between $60,000 and $70,000, while just fewer than 18% are paid between $40,000 and $50,000.

About 9% reported paychecks of between $100,000 and $130,000, while close to the same percentage said they make between $80,000 and $90,000, and a similar number, between $90,000 and $100,000.

The overwhelming majority of respondents — about 88% — got a pay raise in the past year, with most of those increases — 70% — falling in either the 1% to 3% or the 4% to 6% range.

More than 95% said they work in a hospital, and most of those — 75% of the total — for a nonprofit organization. Thirty-one percent chose "director, access management," when asked to select their job title from a list, but another 33% selected "other" in that category.

Among the job titles written in by those respondents were director of admissions; director of patient financial services; director, business services; director, patient financial services and access; and director, revenue cycle.

Most survey respondents — just fewer than 40% — live in the Midwest, while 25% live in the Northeast, and another 20% in the Southeast or the Southwest.

The largest numbers were at opposite ends of the spectrum when it came to longevity in the field, with 22% reporting they had been in the access field between one and three years, and 15% saying they had worked in access more than 25 years.

As usual, female respondents far outnumbered their male counterparts, at about 85%. The largest percentage of those surveyed (28.6%) said they work between 41 and 50 hours a week, while a similar number (27.5%) put their hours at between 46 and 50. ■

HIPAA Regulatory Alert

Supplement to Healthcare Risk Management and Hospital Access Management

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IN THIS ISSUE

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Privacy regulations complicate communication with patients

Balancing confidentiality and safety is a challenge

The privacy regulations enacted as part of the federal Health Insurance Portability and Accountability Act (HIPAA) have caused some unforeseen complications for hospitals trying to ensure patient safety and improve communication between providers and patients, say health care professionals and legal experts.

And as hospitals continue to develop new policies and procedures to comply, it's important that they carefully examine how their efforts will affect caregiver-patient relationships.

"Some of the good things about HIPAA, obviously, were the enacting of standards to ensure continuity of care and maintenance of insurance coverage while switching jobs and health plans," notes **Arnold Rosenbaum**, MD, a practicing surgeon and president of Seacrest DocSecurity, a HIPAA consulting firm in Middletown, RI. "But some of the regulations are actually going to impede care in some ways by slowing things down. It is impairing simple communication where there really needs to be communication."

Because HIPAA allows patients to request total or limited anonymity while in the hospital and to have a significant amount of control of over the dissemination of information about their health conditions, most hospitals have done things such as removing the patient names from large boards behind the nurses' stations and replacing names and other information on wrist bands with bar codes to prevent unauthorized disclosures of information.

While these measures do improve the patient's confidentiality, they can complicate patient care, Rosenbaum says.

"Hospitals have, in good measure, replaced the patient boards with names in most nursing units with boards that have initials or some other identifier," he explains. "But it can become quite difficult to find your own patient. There are added difficulties to patients requesting anonymity because just finding the patient becomes a significant effort for anyone who has to do it, whether it is a physician, nurse, or technician needing to draw blood. You then have more potential for treating the wrong patient, operating on the wrong patient, etc. You have now this dual purpose in preventing errors and mistakes and in maintaining privacy and confidentiality."

Provider communications with family members — already difficult waters to navigate — are even more complicated now because HIPAA

requires that hospitals get written authorization before disclosing information to a third party.

If a patient has established ahead of time that his or her condition can be discussed with a spouse or a child, no problem. However, providers frequently find themselves in other situations, says **William J. Spratt Jr.**, JD, a former health care administrator now a health care attorney with the Miami law firm Kirkpatrick & Lockhart, and vice chair of the Florida Bar Association's Health Law Certification Committee.

"HIPAA has put some constraints and created some doubt as to what the health care provider can do when they are dealing with a patient who is either incapacitated or in an emergency medical condition," Spratt explains. "They are limited in their disclosure. Basically, they have to make a determination of what is in the best interests of the patient and disclose only the personal health information that is directly related to that person's involvement."

So if an 85-year-old woman in Miami suffers a heart attack and is taken to the hospital, and the woman's son in New York calls to speak to the physician, barring any prior authorization from the woman, the physician can only confirm to the family member that the patient is receiving care at the hospital and basic information about the patient's current condition.

"But they cannot talk about it," Spratt explains. "They can't say, 'Mom had a heart attack and we've taken a look at it, and it appears to have subsided; she has some weakness of the upper wall.' They cannot go into that level of detail."

Such efforts to protect the patient may do more harm than good, says Seacrest's Rosenbaum.

"Open communication — communication with both family and other individuals — frequently is very important in patient care," he notes.

Now, physicians and nurses may feel a dual responsibility — to provide information to worried family members about a patient who may need their support and at the same time to protect their hospital and comply with the privacy protections mandated by federal law.

With no clear guidance, hospital personnel can go overboard with compliance efforts and restrict the flow of information even further than necessary, he adds.

"This issue has not been adequately clarified in the hospitals where I have worked," Rosenbaum says. "There may be a specific form relating to who can be spoken with and who cannot be spoken with, but that is very difficult to work with in the heat of the moment."

The overcompliance problem

In their efforts to comply with the privacy regulations, some facilities have gone overboard and restrict information even when they don't have to and when the patient wants his or her health information transmitted elsewhere, Spratt notes.

HIPAA allows the free flow of information among covered entities for the purposes of treatment, payment, and health care operations, without prior patient authorization. But some facilities, under the gun to develop compliance plans, have blanket policies that require patient authorization in all instances.

"My wife had a procedure done in the outpatient center of a hospital and requested that the results be forwarded to her physician once the radiologist interpreted the study," Spratt says. "She called and asked them to send it, and they said they needed either a written authorization or she needed to

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Editorial Questions

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

come down there and pick up the results herself. That is basically a covered entity to covered entity and a disclosure for treatment purposes between a hospital and treating physician, but they were being a little overly cautious, I guess. I had to speak with them to assure them that HIPAA certainly allows them to share the results of diagnostic tests with the patient's physician."

Spratt finds that he frequently has to correct misunderstandings among hospitals and physicians and other providers about the purpose and intent of HIPAA.

"The purpose of HIPAA is not to interfere with the regular ongoing exchange of health care information that is relevant to the common treatment of patients," he notes. "It is really intended more to protect that information from disclosure outside the scope of the treating people and put some limitations on exchange of information between health care providers and insurers so that insurers can't assemble huge databases on patients that may be used for improper purposes — denying coverage of determining pre-existing conditions, things like that."

HIPAA was enacted because the health care industry was so far behind most other industries in terms of automation and use of electronic data and electronic medical records because of myriad state regulations and an overdependence on paper systems.

"HIPAA was invented to set the stage for facilitating the electronic exchange of information in order to increase efficiency and reduce health care costs by eliminating duplicative testing and things of that sort and to make the information more available to treating physicians and providers so that there may be a reduction in errors because information was not available," Spratt explains.

At the same time, Spratt notes, the federal government was concerned that facilitating the efficient exchange of information would enable the establishment of huge databases of medical information about individuals and that this had a huge potential for abuse.

"This is a recurrent theme in federal regulations," he says. "Any time there is an initiative to aggregate substantial amounts of personal data, this element of Congress raises up and says, 'No, that's not what this country is about.'"

So, though the intention of the privacy regulations was to prevent Big Brother from knowing everything about everyone's medical condition, the real-world impact is that a worried sister might not be able to obtain information about her sick sibling hospitalized across the country.

Further complicating matters, HIPAA allows health care providers to provide information to persons without prior authorization if they are allowed to do so under state laws, but only under the specific provisions under those laws.

The only recourse hospitals have is to ensure that they understand HIPAA and its interaction with the laws in their state and that they develop policies that accurately guide their staff interactions with patients, says **Linda Ross**, JD, a health law attorney with the law firm of Honigman Miller in Detroit.

"There are already differing laws in differing states that deal with things like confidentiality and patient records and disclosures and subpoenas, etc.," she explains. "Rather than have HIPAA just trump everything, the lawmakers created a system where if the state law is contrary to, but more stringent than, federal law, the state law remains in place."

In Michigan, the health law section of the state bar spent months in committee going over the different provisions in HIPAA and any related statutes in their state to determine which requirements held.

"We created this tool for the state that is available and a guideline that goes through our analysis and decides what requirements hospitals and other entities in the state must do to comply," Ross says.

As people become more educated about and comfortable with HIPAA, much of the confusion and conflicts will die down, she notes. But for now, hospitals must look at everything they do for how the privacy regulations may have an effect.

They must not only develop policies that require personnel to obey the law but also ensure that the policies don't encourage staff to become so rigid in protecting information that they harm patient relationships or impede patient care.

"Especially things like patient rights — patients have a right to access their records, request amendments, and say, 'Talk to my husband, but not to my son,' or 'Call me on my cell phone, but don't call me at home," Ross says. "The result is that hospitals need to implement behavioral changes, cultural changes, and administrative changes with how they deal with patient information."

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What to do if you're just getting started

Time to prioritize your responses, expert says

At the Seventh HIPAA Summit held in Baltimore in mid-September, "Doctor HIPAA" — former Centers for Medicare & Medicaid Services (CMS) executive **William Braithwaite** — said that while Transactions and Code Sets (T&CS) testing should have started in April at the latest, vendors should have provided software to all their clients and completed testing, clearinghouses should have finished testing for all customers, and health plans should have finished testing all transactions with providers and clearinghouses, the reality was that much of the testing still was being done and some entities hadn't yet started.

Those who haven't started need to understand the reality of their situation in terms of the law and guidances from CMS, a reasonable definition of "compliance," and the consequences of their failure to comply, he said.

"It's time to prioritize your responses and create and promulgate contingency plans," Braithwaite said. "Establish reasonable compliance targets. Coordinate, cooperate, and push your trading partners to become compliant over time."

He reviewed the provisions for civil and criminal penalties and CMS' initial enforcement approach, noting that the agency intends to focus on obtaining voluntary compliance and will use a complaint-driven approach for enforcement.

If CMS receives a complaint about a covered entity, it will notify the organization that a complaint has been received and provide it an opportunity to demonstrate compliance, document good-faith efforts to comply, and/or submit a corrective action plan.

Braithwaite noted that there is no definition of "compliant" in the CMS guidance and said the agency will consider an organization's good-faith efforts to comply when assessing individual complaints.

"CMS understands that transactions require the participation of two entities," he said, "and CMS will look at both entities' good-faith efforts to determine whether a reasonable cause for noncompliance exists and the time allowed for curing the noncompliance. CMS says it will not impose penalties on entities that deploy contingencies to ensure the smooth flow of payments if they have made reasonable and diligent efforts to become compliant and, for health plans, have taken reasonable steps to facilitate the compliance of their trading partners. As long as a health plan can demonstrate its active outreach and testing efforts, it can continue processing payments to providers."

He said covered entities might be able to demonstrate good faith, he said, by steps such as increased external testing with trading partners; lack of availability of, or refusal by, trading partners to test transactions with the entity whose compliance is at issue; and concerted efforts by a health plan before Oct. 16, 2003, and continuing efforts after that date to conduct outreach and make testing opportunities available to its provider community.

Braithwaite urged organizations to document that they had exercised good-faith efforts to correct problems and implement changes required to comply in case a complaint is filed. He said that CMS will expect noncompliant covered entities to submit plans to achieve compliance and that CMS flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the transition to the standards.

(For more information, e-mail Mr. Braithwaite at Bill@braithwaite.com.) ■

Privacy implementation going well, says HHS

Compliance 'widespread,' says OCR director

Department of Health and Human Services Office of Civil Rights director **Richard Campanelli** says that many covered entities have done a good job of coming into compliance with the HIPAA privacy requirements that took effect in April, although there remain some misunderstandings about the requirements that need to be cleared up.

Campanelli presented his assessment in a Sept.

23 testimony to the Senate Special Committee on Aging.

"The privacy rule establishes the nation's first-ever comprehensive standards for protecting the privacy of Americans' personal health records," he said. "As of April 14, 2003, patients have sweeping federal protections over the privacy of their medical records, right to access and to correct errors in their medical records, right to control how their protected health information is used and disclosed, and a clear avenue of recourse if the rights afforded by the privacy rule are violated."

He told the senators that a number of areas that have received a lot of attention since April were significantly changed through modifications to the rule made last August, but some confusion still needs to be addressed.

One aspect of the privacy rule that had been the subject of much public response during the comment period was the requirement to obtain written consents from patients to use or disclose their protected health information to treat them, obtain payment, or carry out day-to-day operations. "Requiring consent in these contexts," Campanelli said, "would have been unnecessarily burdensome on patients and providers, and interfered with timely access to quality care, without improving privacy. It would have meant, for instance, that a doctor would have needed a patient to sign a privacy consent before he could use health information to treat that patient; that a specialist contacted by the patient's doctor would have needed to obtain the patient's consent to read treatment information; and that a pharmacist would have needed the patient's consent to fill a prescription written by the provider."

He said the modifications to the privacy rule removed the requirements that providers obtain prior consent to use or disclose a patient's health information for treatment, payment, or health care operations purposes. Although obtaining such consent is considered the optimal situation, he said, the change assures providers ready access to health information about their patients and the ability to share that information so that timely access to quality health care is not unduly impeded.

According to Campanelli, the notice requirement was strengthened at the same time by requiring direct treatment providers to make a good-faith effort to obtain a patient's written acknowledgement of receipt of a privacy notice. "This ensures that patients have the opportunity to consider the provider's privacy practices, both to be better informed of how their information may or may not be disclosed, and to be informed of their rights," he said.

The modifications also clarified that with reasonable safeguards, uses and disclosures that are merely incidental to privacy rule uses and disclosures will not be considered a violation. Campanelli said the rule recognizes that communications necessary for quick, effective, and high-quality health care might unavoidably lead to overheard communications. For instance, a physician may discuss a patient's condition or treatment regimen in the patient's semiprivate hospital room, or a pharmacist may discuss a prescription with a patient over the pharmacy counter, so long as they take reasonable precautions, such as lowered voices or stepping away from other people.

Misconceptions, not rule, cause confusion

According to Campanelli, "since April 14, 2003, there has been widespread compliance by health plans, health care clearinghouses, and those providers covered by the privacy rule. For example, physicians, hospitals, clinics, pharmacies, health insurance carriers, employer group health plans, and others have distributed notices, required by the privacy rule, that tell consumers about how their health information can and cannot be disclosed, and their rights. . . . Given the extensive scope of the protections established in the privacy rule, implementation has gone smoothly, without the disruption of the health care system that had been predicted in some quarters."

When confusion has arisen, he said, it appears to be not because of problems with the privacy rule itself, but rather because of misconceptions about the rule. In addition, he said, it appears that providers and other covered entities are educating other covered entities where overly restrictive practices were initially adopted and incorrectly blaming them on the privacy rule.

"For example," Campanelli said, "we have heard reports that some covered entities are reluctant to share health information with other providers, for the purpose of treating their patients, claiming that the privacy rule requires that patients execute written consents for these disclosures to occur." Providers who attribute this practice to the rule apparently are unaware that it was modified specifically to permit treatment disclosures among providers without a need for patient consent, he said.

He also mentioned receiving reports of providers saying they cannot share information

with family members or loved ones. The reality, he said, is that rather than foreclosing such communications, the privacy rule provides a number of common-sense methods that appropriately permit such disclosures while respecting and protecting individuals' right to control their health information. In a similar vein, incorrect reports that clergy can't get information they need about congregation members who are hospitalized have circulated. Campanelli reported that hospitals may continue to maintain patient directories with information including a patient's religious affiliation if the patient shares it. He said clergy can always ask for individuals by name and get the information they need, but also can refer to hospital directories if the hospital maintains one.

"It appears that confusion on these issues is dissipating as covered entities and consumers become more familiar with the rule's requirements," he told the committee. "The problems do not arise because of the privacy rule, but rather seem to arise either because providers have elected to take a more restrictive approach than the privacy rule requires, or because of a misconception about the requirements of the privacy rule." He said the Office of Civil Rights has conducted and is continuing to use an extensive public education effort so providers and consumers know what is and is not in the rule.

(Additional information is available from www.hhs.gov.) ■

CMS implements contingency plan

Legacy claims accepted for undetermined period

With surveys indicating that the required Oct. 16 compliance with transaction and code sets (T&CS) HIPAA requirements would be spotty at best, the Centers for Medicare & Medicaid Services (CMS) has drawn industry support for deciding to implement its contingency plan and accept legacy claims for an undetermined period of time while efforts toward full compliance continue.

The announcement from the federal agency was followed by one from the Blue Cross and Blue Shield plans saying that they, too, would accept noncompliant claims for a while, as long as good-faith efforts toward compliance continue.

Representatives of all elements in the HIPAA process praised the decision to avoid a major train wreck of claims not being processed by accepting noncompliant claims, but also stressed the need for all parties to make good use of this grace period by taking the steps necessary to come into full compliance.

As the Oct. 16 T&CS deadline loomed closer, CMS first announced on Sept. 11 its contingency plan for temporarily accepting noncompliant claims. "As the largest HIPAA-covered entity," agency acting deputy secretary **Leslie Walker** said in an announcement, "we at Medicare do understand the difficulties in becoming compliant first-hand. That's why we've been working hard to help our HIPAA partners become compliant. . . . Now we are working on the possibility of Medicare implementing a contingency plan, and I urge other health plans to announce their contingency plans as soon as possible to allow their trading partners enough time to make any needed changes to their business operations to make sure any disruptions in their health care operations are minimal."

Contingency plans will help meet agency goals

CMS administrator Tom Scully later said that implementing the contingency plan moves the agency toward the dual goals of achieving HIPAA compliance while not disrupting provider cash flow and operations. And CMS director of Medicare management **Tom Grissom** said, "Medicare is able to process HIPAA-compliant transactions, but we need to work with our trading partners to increase the percentage of claims in production."

During the contingency period, CMS regularly will reassess the readiness of its trading partners to determine how long the plan will remain in effect. With the contingency plan in effect, there was no chance that the implementation date would be delayed.

American Association of Health Plans vice president for private market regulation **Tom Wilde**r tells *HIPAA Regulatory Alert* that stakeholders accepted the CMS announcement because it's in line with what most health plans will do — accept legacy claims for some period of time from clearinghouses or providers that aren't ready for the Oct. 16 deadline, so long as the submitter is making a good-faith effort to transition to the new standard.

American Medical Association trustee **Joseph Heyman** said his organization had a three-step

plan for a smooth transition to the T&CS standard — 1) physicians finalize plans to become HIPAA-compliant as quickly as possible; 2) CMS implements its contingency plan; and 3) private sector payers also develop contingency plans to allow legacy claims while the transition to full compliance continues.

American Hospital Association officials had called for implementation of contingency plans before the announcement was made and praised CMS for its decision.

Testifying before the U.S. Senate Special Committee on Aging just after CMS said it would implement its contingency plan, CMS Office of HIPAA Standards director **Jared Adair** said experiences in other industries have shown the need for health care to standardize transaction information. "Because the banking industry has agreed upon transaction standards," he said, "customers enjoy the safe use of their bankcards at ATMs around the world. Likewise, standards in the shipping industry make it possible to track and deliver parcels worldwide. Such standards and interoperability will benefit the entire health care industry."

There will be cost savings over time

Adair added that while many entities, including CMS, have revised upward their estimated costs for implementation of the T&CS requirements, because of unexpected complications encountered during the assessment and implementation process, "it is clear that HIPAA is going to improve the administrative costs for everyone in the long term. For example, HIPAA is expected to create significant savings for the health care industry and the taxpayer over the first 10 years of implementation. It also is important to note that HIPAA carries significant cost-reduction capabilities over time, when taking into account the start-up costs currently being incurred. Health care providers will be able to submit bills in the same format to all payers and be assured the bills will be accepted. Providers also will have the ability to query claim status and eligibility by computer rather than over the phone. Plans will not have to keep or store paper claims. This will reduce overhead as well as improve turnaround time for transactions, both of which should have a positive impact on cash flow."

Adair said that despite the significant challenges involved, substantial progress has been made toward T&CS implementation, although the progress was not enough to ensure that all health care providers and payers are 100% ready to support the uninterrupted continuation of the nation's $1.4 trillion in health care payments.

He said as the industry moves toward full implementation, three areas of the process need to be reviewed: 1) use of companion guides that describe situational elements but could be misused to exceed HIPAA standardization requirements; 2) required data elements not necessarily needed to adjudicate a claim; and 3) clarification of implementation guidance that is open to interpretation.

"While difficulties exist in achieving compliance," Adair said, "this is not the time to waver in our commitment to offer order and consistency in health care administrative transactions. Rather, it is a time to work with covered entities as they strive to cross the finish line."

(CMS contingency plan information is available at www.hhs.gov.) ■

Survey shines light on HIPAA compliance efforts

Nonprovider compliance improves

The summer 2003 Industry HIPAA survey conducted by HIMSS (Healthcare Information and Management Systems Society) and Phoenix Health Systems found that "not enough time" was seen as the major roadblock to meeting the Oct. 16 implementation deadline for transactions and code sets (T&CS). And that report helped set the stage for CMS and others to apply their contingency plans and continue to accept noncompliant claims.

In online surveys completed in early July, 81% of providers said they had either completed or expected to have completed their T&CS gap analysis before October. But only 74% said they would have implemented all T&CS changes by October.

The researchers said, "lack of cooperation/communication among industry segments remains an ongoing impediment."

Provider readiness for October for various types of transactions ranged from 1% for "None" and 6% for the 820 transaction form to 76% for the 837. For payers, readiness ranged from 3% "None" and 45% for the 820 to 84% for the 837.

Obstacles cited by providers included payer not ready to test (48%), payer not ready for the transaction type (37%), noncompliant software (29%), and internal data collection (27%).

Nonprovider privacy compliance better

In another aspect of HIPAA, the surveyors said that nonprovider privacy compliance had improved dramatically since the group's spring report. Reporting compliance were 88% of clearinghouses (up from 47%), 81% of vendors (up from 39%), and 85% of payers (up from 68%). At 77% (down from 78% in April), providers were the least privacy-compliant segment of the health care community.

HIMSS and Phoenix said that hospital budgets for HIPAA compliance in 2003 generally are higher than they were in 2002, but spending seems to be leveling off.

Survey information is available at www.HIPAAAdvisory.com or contact Phoenix Health Systems at (301) 869-7300 or e-mail info@phoenixhealth.com. ■

Labs seek HHS transaction guidance and relief

ACLA president testifies before Senate

In testimony before the U.S. Senate Special Committee on Aging, the president of the American Clinical Laboratory Association (ACLA) said that although labs are committed to compliance with the transaction standards, the Department of Health and Human Services (HHS) needs to provide more specific guidance to assist providers struggling with implementation and also must streamline the mechanisms for development and maintenance of the transaction standards.

ACLA president **Alan Mertz** said that clinical laboratories are in a unique position with respect to implementation of the transaction standards because they typically have no direct patient contact and thus little opportunity to obtain much of the information that now is required to be submitted in compliant claims. "Clinical laboratories generally perform testing at the request of a physician, on a specimen they pick up from the physician, and they report test results back to the same physician," he said. "As a result, clinical laboratories must rely on physicians to provide patient information." But, he said, because of other demands on the time of physicians and their staffs, they often fail to provide the information initially and also may not be responsive when laboratories make a point of requesting it.

Mertz made particular reference to the problem of providing patient demographic information and also diagnosis coding, noting that physicians have little incentive to provide a laboratory with diagnosis codes because there is virtually no legal or financial consequences to them for transmitting incomplete information to a laboratory. While the laboratory has no ability to force physicians to give them the information, he said, they have to expend precious resources trying to do so.

"As a practical matter," according to Mertz, "a laboratory cannot refuse to perform testing ordered by a physician. Laboratory testing is a critical, and often time-sensitive, health care service. Most laboratories feel they are obligated to perform the testing that is ordered once they receive a specimen, and the laws of several states specifically require testing on all specimens that are submitted to a laboratory. Further, a laboratory could be held liable if a patient later suffers harm as a result of the laboratory's failure to perform testing ordered by a physician. Thus, the practical reality is that if diagnosis information is required to electronically submit a claim, laboratories will be faced with filing paper claims or will end up doing testing for free when they cannot obtain the required information from a physician."

Mertz also raised questions about the HIPAA regulatory process, noting that the law generally requires the department to adopt a standard that has been developed, adopted, or modified by a standard-setting organization. But the law also requires that any standard adopted be consistent with the objective of reducing the administrative costs of providing and paying for health care and accommodate the needs of different types of health care providers.

Mertz said in addition to comprehensively evaluating the relevant regulatory processes, HHS should provide covered entities with additional guidance on compliance with the transaction standards, including a definition on what constitutes a compliant claim and recognition that less-than-perfect claims may be considered compliant initially.

(Contact Mertz at (202) 637-9466 or go to www.acla.org.) ■