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Move to centralize specialty schedulers is boon to efficiency, customer service

Lost call rates decrease by half; service levels up 40%

When it came to streamlining the way patients, referring physicians, and other interested parties contact Geisinger Health System in Danville, PA, for various access-related services, it seems that one good idea led to another.

Key among a number of initiatives, explains **Carol Swank**, director of the access center, was improving the way customers accessed specialty services — which traditionally had controlled their own scheduling — by centralizing scheduling and moving the specialty schedulers into the system's access center.

"Service levels were not being measured, so they had no idea if they were losing calls," she notes. "The access center [staff] were getting overflow calls [from the specialty practices], but were not able to schedule."

Another issue, Swank adds, was that scheduling for the practices had taken place only between 8 a.m. and 5 p.m., while the access center is in operation 7 a.m. to 9 p.m.

Furthermore, she says, physicians weren't referring patients to Geisinger as often as they should have been, a problem that the system's new chief of operations targeted by forming a team to strengthen physician relations.

With the oversight of **Karen McKinley**, RN, CHAM, vice president, access and care management, the centralization effort got under way, with groups of schedulers brought over in phases to the access center, Swank says. As the process continued, she notes, problems in how the individual clinics did their scheduling began to surface.

"As we brought over the [clinic personnel], we found there was work that was never done, referrals — some that went back several months — that weren't scheduled," she adds. With only one person [in each of the specialty services] to manage access as well as perform other duties, Swank notes, open slots in the schedule often were not filled.

"With the telephones they were using in the clinics, there was no way to look at how many calls they were losing or at their service levels," she

adds. "The only way to find out was if people complained."

During visits to the referring physicians, she says, Geisinger's chief administrative officer found that "the offices had 20 or 30 telephone numbers, 20 or 30 different fax numbers" that were being used to speak with or make referrals to staff or physicians in Geisinger's specialty practices.

Appointments were not made on the initial call, Swank notes. The response, she adds, was always, 'Fax the referral and we'll make the appointment and get back to you.' Often, that never happened; and the [referring offices] would have to make a second call or fax to one of the 20 or 30 different numbers."

With the tendency of fax numbers to change frequently, Swank adds, the sheets containing those contact numbers often were outdated.

A process called Medlink, whereby referring physicians use one toll-free number to call Geisinger, now is in place in the access center, she says, and "has made a huge difference in pleasing our referring physicians."

During the Medlink pilot, Swank notes, the chief administrative officer visited the referring physicians and promised them that they would be able to make an appointment on the first call, and Medlink was advertised and promoted as part of the access center services.

When the schedulers for the specialty services were brought into the access center, Swank notes, they were arranged in "pods," with two pods for the medicine services, such as dermatology, gastroenterology and cardiology; two pods for surgery services, such as ophthalmology, general surgery, and oral surgery; and one pod for pediatrics.

CareLink employees answering calls from the toll-free patient number — who already were working in the call center — were dispersed throughout the pods, so they could back up the specialty schedulers as needed, she adds.

"A lot of patients we serve are out of area and like to use the toll-free number, so before the [specialty schedulers] came here, [toll-free staff] ended up taking the scheduling calls and had to transfer them to the clinics," Swank explains. "We never knew what was happening to the calls."

Now, she says, the two groups of employees can work together, providing service to a patient in one call and making sure appointments are coordinated if, for example, a husband and wife would like to come in at the same time and see different specialists.

The first group of specialty schedulers moved to the access center in March 2002, Swank says, and the process was fully implemented by August 2002.

While the schedulers' service levels and lost call rates still are "not fantastic," they improved dramatically after the groups began working in the access center, she says. Within a couple of months of arrival, Swank adds, each group's lost call rates had decreased by half, and service levels had increased by 40%.

"Combined with efforts to improve patient access in the clinic sites," adds McKinley, "the

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movement to specialty scheduling pods enhanced our ability to meet the needs of our patients."

IVR on the way

A person using the 800 number may reach the surgery pod, for example, when the need is for the medicine group, Swank notes. "That requires [the employee receiving that call] to get up and go over and talk to the medicine pod."

The toll-free number gets a lot of different calls, she points out, ranging from people trying to reach inpatient rooms to those who want to speak to their physicians about a prescription. Of some 38,000 calls per month that come in through that number, she adds, about half have had to be transferred, causing unacceptable service levels and lost calls.

That situation was expected to improve dramatically, she says, with the advent of a sophisticated interactive voice response system (IVR) implemented in late January 2004. A large pharmacy chain that uses the same system for patients to get their prescriptions refilled reports a 99.5% accuracy rate, Swank notes.

With the IVR, she explains, patients will be greeted by a recorded voice, told that the new system allows them to speak their request, and asked to say the name of the physician or department with which they wish to speak.

If the person says "orthopedics," she adds, the system will respond, "I believe you said 'orthopedics.'" After making that selection, Swank says, the patient will be asked, "Is this about an appointment?" If the answer is yes, that call will be transferred to the pod that is scheduling for that department. If not, the call will be sent to the specialty clinic, where the person can speak with a physician.

If the caller speaks a physician's name — Dr. Newman, for example — the system will say, "I believe you said, . . ." and will give its interpretation of what was said, Swank says. If the caller's response is negative, she adds, the system will offer the option of spelling the name.

A pilot of the IVR, involving some 25 internal medicine patients, indicated that about 75% found it easy to use, she points out, even though they weren't reaching the right destination because the system's vocabulary was not fully built.

"What we had to do to build the system," Swank explains, "is to look at what patients actually call these physicians, many of whom have names that are complicated or difficult to pronounce. There were synonyms we had to build in that could identify a mispronunciation."

Similarly, the system had to be tweaked so that it could take callers to the correct department whether they spoke the word "otolaryngology" or said "ENT" or even "ears, nose, and throat," she adds.

Another consideration, Swank says, is that the system is extremely sensitive, and will not work correctly if the caller is carrying on a conversation, or if the television is playing at loud volume in the background, while waiting for a response.

The IVR is expected to enhance the success experienced with the Medlink process, notes **Lynn Schankweiler**, CHAM, Geisinger's manager for system access education, by reassuring referring physicians that they are being connected. In the near future, she says, these physicians will be able to just say, "Transfer center," to reach personnel who will arrange for an admission.

Also down the road, Schankweiler says, the IVR will interface with Geisinger's Epic scheduling system to make the process even more seamless. If the call is about an appointment, she adds, the caller will be asked to state a medical record number or a Social Security number and the person's account information will pop up on the scheduler's screen.

It is anticipated that the new system will increase service levels, allowing for more effective staffing, Schankweiler says. With 40 or 50 calls coming in within 15 minutes, she adds, half of which are nonscheduling-related calls that need to be transferred to other areas, it's been impossible to staff for peak hours.

While those calls now have to be transferred manually — by staffers trained to do a "warm" transfer, making sure the patient is connected properly — with IVR they seamlessly will be routed, Schankweiler points out.

"Overall, it's going to not only increase patient satisfaction, but make staff more efficient and increase productivity by getting patients where they need to be the first time around," she adds. "I believe it will increase staff satisfaction as well, because, from their perspective, it's frustrating when you answer 50 calls and, with 25 of them, you can't help the patient and have to do a transfer."

(Editor's note: Carol Swank can be reached at cswank@geisinger.edu. Lynn Schankweiler can be reached at lschankweiler@geisinger.edu.) ■

Coverage for unfunded is access director's specialty

Initiatives brought millions in reimbursement

"If the front end would just get it right when the patient first comes in . . ." goes the refrain from billers, or the CFO, or some other party focused on putting the blame for unreimbursed care at the feet of the access department.

But when a substantial number of patients walk in without insurance coverage at the time of care or are emergency patients who don't have their insurance information with them, it's not quite that simple, says **Patti Daniel**, MS, CCM, LPC, LMSW/AP. And when many of those patients also are undocumented immigrants, she adds, the challenge is that much greater.

"It's always best to obtain the information up front if it is available; but if it isn't, you have to create processes to identify or develop funding as quickly as possible after the fact," says Daniel. Her focus has been on doing just that during a recent five-year stint as director of admissions and registration at a publicly funded hospital with more than 900 beds. She currently works as a health care consultant based in the Dallas area.

"We were the designated indigent health care provider for the county," she notes. "People came there because [their perception was] the hospital would provide care at no charge."

During her tenure as director, Daniel adds, she created initiatives that recouped millions of dollars in what would otherwise have been uncompensated care. The centerpiece of that effort, she says, was a strong financial counseling unit that comprised several programs aimed at obtaining financial coverage before the patient was discharged and after patient care had been provided.

The 37-week process

Patients who are undocumented U.S. residents — and so not eligible for traditional Medicaid — are eligible for coverage of costs associated with the delivery of a child, which is considered an emergency, Daniel explains.

Although the hospital could receive between $1,800 and $2,200 from Medicaid for the delivery based on the institution's standard reimbursement rate, that reimbursement happened only if the patient was certified for the coverage, Daniel says. While patients would sometimes get certified in order to receive a year of Medicaid coverage for their babies, she notes, they had no incentive to get certified so that their own hospital bill for delivery charges would be covered.

In fact, Daniel points out, undocumented patients often avoided making the Medicaid application that could qualify them for payment of their hospital bills for fear that the hospital would report their illegal status. Meanwhile, she adds, these patients "could care less if we turned the bill over to a collection agency, because they don't care about personal credit. Most are not buying houses or getting a car financed. They're trying to avoid being sent back to Mexico."

In order to recover these hospital delivery costs, Daniel says, "we created what I call the 37-week process. It's pretty simple, but you have to stay right on top of a person's pregnancy and Medicaid application status."

Undocumented patients were identified at their initial prenatal visit and during the 35th week of pregnancy, she notes, and given a Medicaid application to complete. They were told that when they reached the 37th week, they should bring the application back, with the required documents, and would be assisted in applying for emergency Medicaid coverage.

"We explained that the required documentation included such things as a birth certificate, the number of people in the family, proof of residency, and household income," Daniel adds.

The process was facilitated, she says, by a database she created that was shared by the financial counselors at the hospital and those at eight community-based prenatal clinics, who worked in tandem to get the patients' bills covered by Medicaid.

In the 37th week, Daniel explains, hospital financial counselors made an appointment for the patient with a hospital-based Medicaid eligibility worker to complete an application, which was put on pending status until delivery. The financial counselors, meanwhile, created a pending pre-admission account, which was tracked through the expected delivery date.

Timing was crucial, she adds, because Medicaid workers are allowed to hold an application only about a month before a decision must be made.

"That allowed about four weeks after the application was submitted for the person to deliver, which typically happens in the 40th week, Daniel says. During that hospital stay, financial counselors immediately assisted the

patient in completing the two or three remaining forms required for coverage and made sure she added the new baby to the application.

Patients in this group move frequently, she notes, and often live with relatives. "Once they leave the hospital, you've missed the golden opportunity [to obtain coverage].

"This process resulted in the highest certification rates ever for that hospital — 92% for the mothers and 96% for the babies — and some of the highest in the state of Texas," Daniel adds.

After creating the follow-up unit, she says, her staff began identifying patients who had followed through with applying for Medicaid but never let the hospital know of their certification.

To make the identification process cost-effective, she says, the unit checked Medicaid status electronically. "We sent large files containing inpatient names to the state Medicaid office through a clearinghouse and received matching patient names that were certified for Medicaid. There could be as many as 450 women in the state of Texas during a specific month with the same name; so research — finding the right birth date, double-checking addresses — had to be done once the list of matches came back."

'Spend-down' candidates sought

Another function of the self-pay follow-unit was tracking people who qualified for the "spend-down" program, Daniel explains, which applied to those who had enough income that they were not eligible for traditional Medicaid.

If the people — whether couples or single adults — had children, and if they had unpaid medical bills, she says, they sometimes qualified for Medicaid even if the income was much greater than allowed by traditional programs. "There were still income guidelines, but they were not as stringent."

To determine the spend-down amount, Daniel says, financial counselors referred patients to the Texas Department of Health Services (TDHS), whose Medicaid eligibility workers took the person's financial statement and did an accounting of household bills. "[The patient] might be required to pay, for example, $600 of his or her medical bills before TDHS would begin reimbursement to the hospital," she explains. "[TDHS] figures out what is left after such expenses as gas, water, rent, unpaid medical bills, and transportation to work. These allowable expenses represent the spend-down amount. Medicaid reimburses the hospital on Medicaid rates less the spend-down amount."

While the typical procedure is that people applying send in their bills and Medicaid reimburses them, Daniel says, she found that patients could not be counted on to complete that process.

"It's a complicated program to administer, so we worked out a system," she adds. "We monitored patients with continued medical bills, tracked the bills for them, and got a waiver signed so we could send the information in to Medicaid for them."

The reimbursement generated in this way "represented millions of dollars a year to the hospital," Daniel notes.

Inpatient non-OB initiative

Another self-pay initiative involved training five or six financial counselors to screen for potential disability determination benefits, she says. "What we were looking for is the person who was not eligible for anything else — no Medicaid, no Medicare, no minor children in the home, minimal income, and not pregnant."

A patient who might qualify for this assistance "could be a burn victim, someone in a car wreck, or a person with severe trauma, such as a head injury, who will be disabled for at least 12 months," Daniel explains.

The counselors helped the patients complete an application for disability through Social Security or the Supplemental Security Income (SSI) program, she adds. SSI is designed to help aged or disabled individuals who don't qualify for traditional Social Security or whose Medicare benefit is below a certain limit, Daniel notes.

"They may be eligible for both [Social Security and SSI], so we applied for both. It takes a long time, an hour to an hour and a half, to complete the screening interview and the application."

Without the proactive step of interviewing the person while he or she is still in the hospital, Daniel points out, the opportunity is often lost. "They leave, and a lot of times they don't go home. They are so sick, they might go to a rehabilitation center, or they could move, and then you've lost a way to reach them."

While the reason for the effort is to get patients' medical bills paid, she notes, those who qualify also benefit in another way. "If they get on the program, they get a disability check to help with living expenses."

(Editor's note: Patti Daniel can be reached at lpcdaniel@msn.com. Look for more on how Daniel designed a successful access department in the March issue of Hospital Access Management.*)* ■

GUEST COLUMN

Why not more outsourcing? It's about control

By **Elizabeth Guyton**
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It's easy to make the case that many administrative transactions health organizations routinely handle in-house can be done better, faster, and more cost-effectively by outside vendors. Outsourced revenue-cycle processes benefit from improved methodologies, state-of-the-art information technology (IT) infrastructures, accessible and knowledgeable personnel, economies of scale, and a shared services approach.

Yet less than 1% of health organizations outsource all of their revenue cycle processes. Many more outsource their business processes piecemeal — contracting with outside vendors to handle back office functions such as transcription, a portion of accounts receivable collections, and denial management, while keeping other processes such as insurance verification, pre-certification, pre-registration, billing, and insurance collections in house. Why isn't total revenue cycle outsourcing more widely — and broadly — embraced? It's all about control.

Controlling cash flow

The revenue cycle controls the cash flow through a health organization — or any other enterprise that charges for its services. Giving up control of these vital revenue-generating functions, even to vendors who can demonstrate they can do them better, is a frightening and potentially risky proposition. Health organization administrators are understandably reluctant to put their cash flow at risk by putting key revenue cycle processes and point-of-service functions in the hands of outside — and often offshore — vendors.

Instead, health organizations traditionally outsource low-risk administrative processes that require little health care expertise and little or no direct interaction with patients. Still, even risk-averse administrators must come to terms with competitive pressures that include rising consumer expectations, the need to keep a lid on rising health care costs, and ever-narrowing operating margins. They're tired of fixing administrative processes over and over again, spending good money after bad to improve antiquated, labor-intensive processes, replace compartmentalized IT resources with integrated systems, and maintain a high level of training for staffs with notoriously high turnover rates.

Outsourcing revenue cycle processes has the potential to solve these challenges. Today's robust IT networks permit transparent, global sharing of integrated information. Still lacking, however, are mature, tested solutions that can automate business processes throughout the revenue cycle.

The need to keep control of a health organization's vital revenue stream in-house has limited outsourcing primarily to back office administrative processes. This situation is changing rapidly. Vendors are gaining more experience in the unique business model of health care providers and beginning to offer better products that

Revenue Cycle Processes

Front End				Back End				
Admitting	Registration	Scheduling	Pre-Certification	Transcription	Coding	Pre-Bill	Billing	Collection
		Bed management Resource management	Insurance verification			Electronic charge capture	DFNB maintenance	Cash acceleration Denial management Self-pay follow-up Third-party collection follow-up

streamline processing while incorporating leading practices.

As a result, Stamford, CT-based Gartner Group Inc. research predicts increasing acceptance of business process outsourcing, in both numbers of adopters and the breadth of processes that are candidates for outsourcing. Industry analysts predict that, by 2008, 70% of all health care payers will engage in business process outsourcing and 50% of all health care providers will have piloted business process outsourcing for at least one mission-critical application. Through 2006, health care organizations will claim that they are outsourcing business processes to reduce processing time. The real reason will be to save money.

Outsourcing's value proposition

A health care organization's revenue cycle is composed of an array of processes that begin before a patient is admitted and continue through the final disposition of all charges. Any of them can be outsourced, either on-site or off-site, to reduce operating costs. **(See table, p. 18.)**

The rationale for outsourcing is simple: outsourced services cost less. Compared to in-house processing of revenue-cycle processes, outsourcing delivers substantial, sustainable cost benefits. The outsourcing process begins by identifying "quick-hit" process improvements that can improve financial performance. Leading-practice revenue processes combined with enabling technologies and skilled personnel create an environment where financial improvements can be sustained. Common benefits include:

- 10%-15% improvement in cash flow;
- 20%-30% decrease in accounts receivable;
- 5%-10% reduction in the cost per collection;
- 1%-3% increase in net revenue.

Going offshore with outsourcing

The goal of processing administrative functions offshore is to provide, at minimum, an acceptable level of service for lower cost. The cost savings are compelling. In India, the cost of fulfilling business processes is one-fifth the cost of processing those same transactions in the United States. Outsourcing firms in India, in particular, are investing in the telecommunications infrastructure and employee training to support an explosion in business process outsourcing.

These firms are branching out successfully from providing product technical support to processing mission-critical business transactions. Indian outsourcing firms can provide better-educated, more highly trained personnel for processing health care-specific revenue cycle functions. Experience has shown that offshore fulfillment of business processes actually improves patient satisfaction, and costs one-fifth as much as performing these same functions in-house.

Should your organization outsource?

Organizations that have outsourced their revenue-cycle processes cite the following chronic problems as factors compelling the change:

- Frustration with repeated fixes to revenue cycle processes that don't stay fixed.
- Difficulty in recruiting and retaining patient account executives.
- Rapid turnover and consequent high training costs for billing staff.
- Operating costs that keep increasing while performance decreases.
- Difficulty in monitoring compliance with government regulations.
- Failure of in-house operations to maintain consistent and acceptable performance metrics that include:
  — gross days in accounts receivable;
  — percentage of accounts receivable aged more than 90 days;
  — denials and bad debt as percentages of gross revenue.

Good outsourcing candidates?

Obviously, health care organizations should consider outsourcing processes that create one or more of the challenges listed above. Processes that cost too much and/or deliver poor financial performance are prime candidates. Where control is an issue, organizations may choose to outsource only a portion of a revenue cycle process, such as keeping collection of current accounts receivable or small balances in-house while outsourcing collection of large balances or accounts more than 90 days old. Processes that require extensive redesign or retooling should be considered outsourcing candidates.

Outsourcing affords the opportunity to transform revenue cycle processes to a desired future state while moving the actual work to outside resources. It also places responsibility for IT upgrades on the outside vendor. There are contraindications to outsourcing, too. Sometimes,

community buy-in is an issue. Reducing in-house staff to send work outside the community — or even outside the country — may create animosities and patient dissatisfaction that cost savings cannot justify.

Cost is the critical criterion

Outsourcing helps an organization reduce operating costs. In today's "no-margin-no-mission" health care environment, keeping internal control of all revenue-cycle processes simply costs too much. Each organization must decide for itself which processes it is willing to put into capable, but external, hands

(Editor's note: Elizabeth Guyton is a vice president in the health consulting practice of Cap Gemini Ernst & Young. She leads the national revenue transformation service line. She has more than 20 years of health care management experience concentrating in the areas of accounts receivable and financial management. In the March issue of Hospital Access Management*, Guyton offers a step-by-step approach to outsourcing the revenue cycle.)* ■

New access career ladder adds incentive, fairness

'Morale has been wonderful'

Access personnel at the University Hospital of Arkansas in Little Rock can look forward to moving up a recently established career ladder that is boosting morale as well as paychecks, says **Mary Nellums**, CHAM, admissions manager.

As is true at many health care organizations, the access department had been plagued by employee turnover, she notes, in part because of a discrepancy in work requirements between inpatient registrars and staff performing registrations in ancillary departments.

Salaries were about the same for those working with inpatients and in the emergency department (ED) as for clinic employees, although the clinic job is much less demanding, Nellums explains. "[Inpatient registrars] have to do a lot of different types of registrations, including admitting newborns and labor and delivery patients. They have to remember how to register an observation patient and someone who is having outpatient surgery."

In addition, Nellums says, registrars in the ED — where turnover was particularly high — have to rotate taking weekend shifts and often have to work holidays. "We would train [inpatient] staff and they would end up leaving to work at the clinics."

Under a new tiered system that has been in effect since November 2003, she adds, job descriptions have been established for level one, two, and three registrars, with placement on the career ladder dependent on a combination of factors.

"When we finally got approval to give this incentive to move up, we did a career ladder scoring sheet based on five criteria," Nellums says. **(See scoring sheet, p. 21.)** "We gave 20 points for each section, based on registration accuracy, attendance, patient/registration delays, customer service, and whether [the employee] worked within the parameters of established hospital and department policies, procedures, and protocols."

Because registration audits are regularly performed by revenue integrity personnel, she notes, "it's easy to go back and pull a certain person's accuracy report. We started at [assigning] 20 points for 100% accuracy, and those who went below 94% got zero points."

The other information needed for rating employees also was right at hand. Nellums adds. "Attendance was easy [to measure], and it was easy to see if there were patient or registration delays or customer complaints."

Access representatives who scored 0 to 33 points stayed at the existing salary level of about $22,000 a year, she says, while those who scored 34 to 67 points moved to level two, which added just under $3,000 per year. Sixty-eight points or more put an access rep at level three, with a $5,000 increase over the level-one pay.

New hires, Nellums explains, automatically fall into level one unless they have extensive experience or education. The flexibility exists to bring more experienced individuals or those with degrees in at a higher level, which is a more subjective aspect of the system, she notes.

Of the 18 admissions employees, Nellums adds, three stayed at level one, 12 went to level two, and three went to the third level.

"Morale has been wonderful," she says. "I explained to each person individually where they were, and the reasons why, and told them, 'Here are the areas in which you need to improve; and if

(Continued on page 21)

Career Ladder Scoring Record

Reporting Period: _____ Employee Name: _____

Evaluator: _____ Date: _____

Standard (Max 20 points per section)		Points
Registration Accuracy	**Points Possible**	____
94% or less	0	
95%	5	
96%	8	
97%	11	
98%	14	
99%	17	
100%	20	
Attendance		____
> more than 3 unscheduled absences	0	
> 1 unscheduled absent days or tardies	10	
0 unscheduled absent days or tardies	20	
or		
works > 1supplementary shift to provide coverage when needed	5	
works > 3 supplementary shifts to provide coverage when needed	10	
Patient/Registration Delays		____
> failed to notify supervisor of delays	10	
supervisor notified of all delays	20	
Customer Service**		____
> 1 customer complaint	0	
no customer complaints	10	
Five star, STAR, or some other formal Recognition received	20	
Works within parameters of established hospital and departmental policies/ procedures/protocols		____
> 2 breaks in "PPP"	0	
"PPP" followed as established	10	
Works independently and leads staff As appropriate	20	

Total points _____

** Customers include patients, families or significant other, peers, other departments

Score Outcome:
0-33 points = $22,148
34-67 points = $24,921
68-100 points = $27,694

Total Salary Requested _____

Source: University Hospital of Arkansas, Little Rock.

you do, here is where you can go.' Some are about five points away from the next level. They are so excited that they have somewhere else to go."

While it is difficult to determine the exact cause-and-effect dynamic, Nellums notes, "accuracy has gone up for several people. I'm not sure if it's just an adrenalin rush, but we're looking to see if it continues."

The main difference between access levels two and three is that reps who have reached the higher level are expected to serve as "leads" or preceptors, and to fill in as supervisor as needed, she says. "They're able to use more [computer] functions," Nellums adds, "such as being able to go back into an account and do updates and corrections."

In addition, she says, level-three employees "are skilled insurance/financial counselors and have more years of experience and educational background."

The score sheet, Nellums adds, helped determine where existing employees would fall. "An additional $500 for each year of actual hands-on experience — up to four years — was added to base salary."

The department's insurance representatives, she notes, already are at a higher salary range — about $29,000 a year — and as yet are not part of the career ladder. "We're looking at a way to build in some incentive for them as well."

To ensure the successful establishment of the career ladder, Nellums points out, "we worked hand-in-hand with [the] human resources [department] to make sure we didn't do anything wrong. We are part of a university and have a lot of rules and guidelines."

To avoid any misunderstanding, she recommends letting staff know from the beginning what the new job descriptions will entail. "Once you determine you can give more money," Nellums adds, "sit down with employees and let them know more will be expected: 'Here's the plan, but I need to know that you are willing to give me more.'"

[Editor's note: Mary Nellums can be reached at NellumsMaryC@uams.edu.] ■

ACCESS FEEDBACK

Myriad laws specify treatment consent rule

Get form signed consistently, AM cautions

Access departments are playing with fire if they don't consistently obtain consent for treatment *before* treatment is given, emphasizes **Susan Baxley**, corporate admitting manager for Sacramento, CA-based Adventist Health System.

Baxley was concerned, she says, after reading in the December 2003 issue of *Hospital Access Management* that the emergency department (ED) at St. Mary's Hospital in Leonardtown, MD, sometimes is not able to get the medical consent signed until after care is provided and that, in some cases, people have refused to sign it.

What has happened, explained **Natalie Woodburn**, RN, a patient registration supervisor in the St. Mary's ED, is that people who have brought in minors for treatment have refused to sign the consent form because they are afraid of being responsible for the bill.

Baxley points out that the legal requirement for patient consent to treatment is common to all jurisdictions and may be found in court decisions as well as in various statutes and regulations.

While she suggests that access managers research the laws of their individual states, Baxley offers some examples from states in which her health system's hospitals are located:

Those who work in California hospitals, she notes, can consult the California Healthcare Association (CHA) manual, which states in Chapter 1, Section II B, Emergency Treatment Exception, "The physician must initially determine whether the patient is competent to give consent, since the emergency exception applies only when consent cannot be given."

The manual may be ordered from the CHA web site: www.calhealth.org.

For those in Oregon, she cites House Bill 3294, Section 2 (1), which states, "A physician shall obtain a patient's informed consent prior to administering a proposed procedure to diagnose or treat a disease or condition."

More information is available at: http://pub.das.state.or.us/LEG_BILLS/PDFs/HB3294.pdf.

The issue also is addressed in the Medicare Conditions of Participation, Baxley notes, under the provision on patient rights (42 CFR 482.13 b),

which includes the right of the patient to make informed decisions regarding care and to participate in the development and implementation of the plan of care.

In addition, standards of the Joint Commission for the Accreditation of Healthcare Organizations standards describe the right of patients to be involved in all aspects of their care (RI.1.2) and to give informed consent (RI.1.2.1), Baxley adds.

She also recommends reviewing a web site sponsored by the Louisiana State University Law Center: //http:biotech.law.lsu.edu/books/aspen/Aspen-Chapter-9.html.

To avoid the potential legal tangle around the obtaining of consents, Baxley says, Adventist Health System has adopted a two-part consent form. The first part contains the medical consent and the second part is the financial consent.

The two-part consent was instituted just before the Health Insurance Portability and Accountability Act privacy standard went into effect, she adds, as part of the system's efforts to stay in compliance with Emergency Medical Treatment and Labor Act regulations and with state and federal consent laws.

"The medical consent section is signed as soon as the patient presents — as long as it does not delay treatment — and the financial consent is signed as soon as the medical screening exam (MSE) has been completed," she explains.

Baxley suggests that Woodburn's facility, which already is gathering the patient's name and date of birth upon arrival, also get the medical consent signed at that time, as long it doesn't delay treatment.

To facilitate the efficient collection of patient data, Baxley notes, Adventist registration departments are encouraged to work with ED physicians and clinical directors to develop MSE notification systems, whereby registrars are notified immediately when the MSE is completed.

"This has enhanced our ability to sign forms, update accounts, and collect monies due from patients," she says. "Most of our facilities have been very responsive."

The key to gaining clinicians' cooperation, Baxley adds, is to explain to them the financial importance to the health system of obtaining accurate, up-to-date patient information. At Adventist, she notes, that has included sharing with ED directors the number of denials and the amount of bad debt coming from the ED.

"They care about customer satisfaction and the health of the patient, but if they also realize that it's not just, 'I need to get this form signed,' but, 'Here are the financial implications of this,' it helps us work together as a team."

[Editor's note: If you have feedback on this or another access issue, please contact editor Lila Moore at (520) 299-8730 or at lilamoore@mindspring.com. Susan Baxley can be reached at BaxleySF@ah.org.] ■

Study: Growth slows in health care spending

The growth in health care spending declined by 1.5 percentage points in the first half of 2003 — the largest six-month drop since the early 1990s, according to a recent study by the Center for Studying Health System Change.

The study found an 8.5% increase in health care spending growth per privately insured American during the first half of 2003, down from a 10% rise in the second half of 2002. Spending on hospital inpatient care grew 7.6% during the first half of 2003, down from an 8.3% increase in the last six months of 2002, the study said, while spending on outpatient care grew 12.9% in the first half of the year, down from 14.1% for the second half of 2002.

The study notes that hospital compensation costs for nurses and other workers have increased significantly over the past few years in response to work force shortages, creating cost pressures for hospitals. ▼

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OIG seeks proposals for safe-harbor provisions

Proposals for developing new or modifying existing safe-harbor provisions under the federal anti-kickback statute will be accepted by the Department of Health and Human Services' Office of Inspector General (OIG) through Feb. 10.

The statute penalizes individuals or entities that knowingly offer, solicit, or receive remuneration to induce or reward business reimbursable under federal health care programs. The provisions specify payment and business practices that would not serve as a basis for sanctions under the statute. To date, OIG has developed 22 final safe harbors or practices that are sheltered from liability.

The notice published by the OIG also solicits recommendations for new special fraud alerts, which provide guidance to health care providers regarding potentially fraudulent or abusive practices.

For more information, see the *Federal Register* notice at www.access.gpo.gov/su_docs/fedreg/a031212c.html under "Inspector General Office, Health and Human Services Department." ▼

AHA survey shows hospital use rising

More Americans turned to hospitals for care in 2002, according to findings from the American Hospital Association's (AHA) latest Annual Survey of Hospitals.

The survey of more than 5,700 hospitals shows admissions at community hospitals rose by 664,691 in 2002. Inpatient days climbed by roughly 2.5 million, while the average length of stay held steady at 5.7 days. Emergency visits jumped by 3.9 million, and total outpatient visits rose by more than 17 million.

These statistics can be found in AHA's Hospital Statistics 2004 Edition, for sale at www.ahastatistics.org or by calling (800) 242-2626. ▼

CMS publishes quality survey tool

The Centers for Medicare & Medicaid Services has published a revised survey instrument and proposed administration instructions for the patient perceptions of care survey known as HCAHPS (Hospital Consumer Assessment of Health Plans).

The survey, which will become part of the hospital-led Quality Initiative, is intended to allow for an accurate comparison of patient satisfaction across hospitals. As recommended by the American Hospital Association and others, the survey was shortened considerably — from 66 questions to 32, 24 of which will gauge patients' perceptions of the hospital environment and care they received and eight will be used to determine demographics and patient mix.

Hospitals will be permitted to incorporate the survey into their current patient satisfaction survey by adding up to 30 questions following the 24 core HCAHPS questions and to use their current survey vendor to administer the survey. ■

HIPAA Regulatory Alert
Supplement to Healthcare Risk Management and Hospital Access Management

Privacy expert urges clarification for privacy regs

Health Privacy Project advocates increase in technical guidance

Health Privacy Project executive director **Janlori Goldman** said that while many glitches and misinterpretations of the HIPAA privacy regulation have been resolved, others remain and should be addressed by the Department of Health and Human Services (HHS) or Congress.

Goldman made her comments in testimony before a subcommittee of HHS' National Committee on Vital and Health Statistics.

"Where misinterpretation persists," she said, "we urge that both the HHS Office of Civil Rights and the professional and trade associations representing providers, plans, and others affected by the law aggressively step up their technical assistance and guidance. We believe that resources should be devoted to proper and vigorous implementation, and not to using misunderstanding and mishap to build public opposition to the law."

Goldman told the subcommittee that the HHS Office of Civil Rights has received thousands of complaints from consumers since the implementation of the privacy regulation, and a number of the complaints have been referred to the Justice Department as possible criminal violations of the rule. However, no penalties have as yet been imposed.

Five changes sought

She listed five areas in which the privacy rule should be strengthened:

1. Enforcement provisions should require a covered entity to disclose information to law enforcement only in response to a court order issued by a neutral magistrate under a Fourth Amendment probable-cause standard.

2. The section on use of health information for marketing purposes should be strengthened by expanding the definition of marketing and should reinstate the rule's original safeguards that required covered entities to give consumers notice if a communication was generated by a third party with remuneration to the covered entity and allowed consumers to opt out of further such communications.

3. The scope of the rule should be expanded so that the list of covered entities includes employers, life and disability insurers, pharmaceutical companies, and others who collect sensitive information directly from consumers.

4. People should be given the right to sue under the privacy regulation if their rights are violated.

5. HHS should be required to conduct periodic compliance reviews of covered entities and make a bigger effort to educate the public about its rights under the privacy rule, if it is going to rely on complaints from the public for enforcement.

(For more information, go to www.healthprivacy.org.) ■

The HIPAA privacy rule: Sorting myths from facts

Expert responds to 13 persistent HIPAA myths

In testimony late last year before the Department of Health and Human Services' (HHS) National Committee on Vital and Health Statistics' Subcommittee on Privacy and Confidentiality, Health Privacy Project executive director **Janlori Goldman** submitted 13 common myths that persist about the HIPAA privacy regulation and the facts that respond to those myths.

Myth: One doctor's office cannot send the

medical records of a patient to another doctor's office without the patient's consent.

Fact: No consent is necessary for one doctor's office to transfer a patient's medical records to another doctor's office for treatment purposes.

Myth: The HIPAA privacy regulation prohibits or discourages doctor/patient e-mails.

Fact: The Privacy Regulation allows providers to use alternative means of communication, such as e-mail, with appropriate safeguards.

Myth: A person cannot be listed in a hospital's directory without his or her consent, and the hospital is prohibited from sharing a patient's directory information with the public.

Fact: The privacy rule permits hospitals to continue the practice of providing directory information to the public unless the patient has specifically chosen to opt out.

Myth: Members of the clergy no longer can find out whether members of their congregation or their religious affiliation are hospitalized unless they know the person by name.

Fact: The regulation specifically provides that hospitals may continue the practice of disclosing directory information "to members of the clergy," unless the patient has objected to such disclosure.

Myth: A hospital is prohibited from sharing information with a patient's family without the patient's express consent.

Fact: Under the privacy rule, a health care provider may "disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual," the medical information directly relevant to such person's involvement with the patient's care or payment related to the patient's care.

Myth: A person's family members no longer can pick up prescriptions for a patient.

Fact: Under the regulation, a family member or other individual may act on a patient's behalf to "pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information."

Myth: The privacy regulation mandates all sorts of new disclosures of patient information.

Fact: HHS has said disclosure is mandated in only two situations — to an individual patient upon request, or to the HHS Secretary for use in oversight investigations.

Myth: The HIPAA privacy regulation imposes so many administrative requirements on covered entities that the costs of implementation are prohibitive.

Fact: The White House has projected a net saving of $12 billion to the health care system over 10 years as a result of implementation of the standards. The cost of implementing privacy over 10 years is estimated at $17 billion, and savings from putting transaction standards in place are estimated at $29 billion over 10 years. Additional long-term savings are expected as patients develop more faith in the health care system and thus are less likely to withhold vital information from their doctors and will more readily seek care.

Myth: Patients will sue health providers for not complying with the HIPAA privacy regulation.

Fact: The regulation does not give people the right to sue. They must file a written complaint with the HHS Office for Civil Rights. Although the agency has authority to assess civil penalties, it has said that enforcement will be complaint driven and that penalties will be imposed only for willful violations.

Myth: Patients' medical records can no longer be used for marketing.

Fact: Use or disclosure of medical information is explicitly permitted for certain health related marketing activities under the regulation.

Myth: If a patient refuses to sign an acknowledgement of receipt of a health care provider's notice of privacy practices, the provider can, or must, refuse to provide services.

Fact: The regulation grants patients a "right to notice" of privacy practices for protected health information, and requires that providers make a "good-faith effort" to get patients to acknowledge that they have received the notice. But the law does not give providers either the right or the obligation to refuse to treat people who do not sign the acknowledgement, nor does it subject the provider to liability if a good-faith effort is made.

Myth: The regulation imposes many new restrictions on hospital fundraising efforts, making it almost impossible.

Fact: According to the rule, a hospital may use, or disclose to its "business associate" or an

institutionally related foundation, demographic information and the dates of health care provided to an individual "for the purpose of raising funds for its own benefit, without an authorization" from the patient. Such use or disclosure is not permitted unless disclosed in the notice of privacy practices.

Myth: The press no longer can access vital public information from hospitals about accidents or crime victims.

Fact: HIPAA allows hospitals to continue to make public, including to the news media, certain patient directory information, including the patient's location in the facility and condition in general terms, unless the patient has specifically opted out of having such information publicly available. ■

Hospitals having problems with privacy reg, AHA says

Three aspects of rule creating unnecessary burdens

American Hospital Association (AHA) attorney **Lawrence Hughes** said there are aspects of the privacy rule that still are not working well and are creating unnecessary burdens for hospitals, with little benefit to patients.

One of the biggest concerns that hospitals have, Hughes told a subcommittee of the Department of Health and Human Services (HHS) National Committee on Vital and Health Statistics, is the burden associated with the accounting of disclosures requirement. "This burden requires that hospitals, even if they haven't received any requests for accounting, create an enormously burdensome paperwork system to be prepared to respond to any accounting," Hughes said.

He reported that the AHA has put together a proposal for a less burdensome approach to the need to get information to patients and has discussed it with HHS staff.

Another area of concern for hospitals, according to Hughes, is the "burden of trying to negotiate and deal with folks who are requesting that they become business associates." He said it seems that many organizations want to become business associates under a mistaken impression that being a business associate would give them the opportunity to get information and use it in multiple ways that are prohibited under the Privacy Rule.

According to Hughes, hospitals have to deal with such requests daily, and there is a need for education and guidance directly from the HHS Office of Civil Rights because organizations that want to become business associates often don't seem to believe what hospitals tell them. "So," he said, "they need some sort of backup educational materials coming directly from OCR that would help them in addressing those kinds of mistaken impressions about business associate agreements." ■

Survey shows physicians not ready for HIPAA

Fewer than 50% perform background checks

Rhode Island's Seacrest DocSecurity surveyed more than 500 physicians nationwide late in 2003, questioning them on requirements that insurance companies ask for before underwriting physicians and hospitals for insurance, and concluded that while physicians generally believe they are HIPAA-compliant, in fact they have only met a portion of the HIPAA requirements, leaving them vulnerable to lawsuits.

"Records, quite literally, are the lifeblood of a medical practice," the company's report says, "and doctors take, keep, and transmit those records in any of a number of ways, from walking a folder down the hall to faxing them to consulting physicians to storing information in centralized, digital directories. Protecting the information in all of these different forms is easier said than done."

Among the survey's findings:

• 36.2% of those surveyed said that because they or their employees have been through privacy training, they are HIPAA-compliant. Seacrest says typical training programs don't even touch on the digital or physical security aspects of HIPAA and don't take into account the maintenance and destruction of records as specified by the law.

• Fewer than 50% of the physicians surveyed perform background checks on employees. Seacrest points out that physicians' offices are small businesses and as the business owners, the physicians are responsible for the actions of their employees. "If a staff member steals medical information and sells it to a third party, it is the

doctor/owner who is responsible for that action," the company says. Seacrest says that physicians should not confuse a background check with a reference check when considering new employees. A true background check, it says, would involve discovering and assessing any criminal activity a potential employee was involved with. It notes estimates that as many as 14% of hospital employees have criminal records.

• Nearly 40% of physicians surveyed do not secure electronic data transmissions. At the very least, according to Seacrest, physicians should be taking steps to keep hackers from accessing files as they are being transferred. It's one thing if the practice is using e-mail for simple office transactions, but file transfers often contain billing information, which requires diagnosis coding that is personal information. "Not encrypting the data is similar to dropping a bill in the mailbox without an envelope," the company says. "The fact that four in 10 don't bother with encryption is disturbing."

Even at this late date, 14% of practices said they had not isolated or locked file cabinets or record rooms, and 27% said that fax machines were not kept in a secured, locked area.

[Additional information is available from Seacrest at (401) 851-2022 or e-mail info@seacrestdocsecurity.com.] ■

HIPAA Q & A

Question: Does the security rule specify how a risk analysis must be conducted?

Answer: The security rule requires all covered entities to perform an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information in its possession, says **Robert W. Markette Jr.**, an Indianapolis attorney. "The rule does not specify how a covered entity should perform this assessment," he says. "Frankly, even computer security experts don't all use the same methods."

The goal of a risk analysis is to identify potential risks and their likelihood of occurring, he explains. A risk assessment can be performed by hiring outside consultants or can be performed by the surgery staff, Markette says. "Programs will need to use their own judgment when deciding whether to handle the risk assessment on their own or to hire outside consultants." The decision may depend on the program's individual staff resources and expertise, he adds.

Question: How should passwords be chosen to ensure security?

Answer: There are rules of thumb for choosing passwords, Markette says.

"First, do not use words from the dictionary or obvious words such as relatives' names or pets' names," he emphasizes. "Do not use your birth date or a relative's birth date," he says.

Birth dates and names are learned easily and often are the first things a hacker will choose when guessing a password, he explains.

"Generally, a password should be a combination of letters, numbers, and, perhaps, even other ASCII characters," Markette suggests. "Of course, this is a two-edged sword." The more complicated the password, the more difficult it is for a hacker to guess, but it also is more difficult for an employee to remember, he adds. Complicated passwords are of absolutely no value for security purposes if the employee writes it on a note that is stuck to the computer screen, he says.

There are a couple of ways you can come up with difficult-to-guess but easy-to-remember passwords, Markette adds. "You can combine somebody's initials with the last four digits of another person's phone number, or take the first letter from each word in an easily remembered phrase and combine it in some way with a birth date or phone number," he suggests. For example: The phrase "Asta la vista baby" combined with the last four digits of a phone number could become any of the following: alvb5543, a5l5v4b3, 5543alvb, 5a5l4v3b.

"None of these passwords are easily guessed, but for the employee, they should be simpler to remember than trgh678# or some other randomly generated password," he explains.

Question: Can a home health agency post thank-you letters from patients on a bulletin board that can be seen by staff and other patients?

Answer: "In my opinion, they cannot post the letters unless the letters are de-identified so they no longer constitute protected health information," Gilliland says. "De-identification" is a process under the privacy rule by which health information is made to no longer be individually identifiable. "Typically, it requires removing all of 18 identifiers stated in the privacy rule including names, geographic subdivisions smaller than a state, most zip codes, telephone numbers, and medical record numbers," he says. ■