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Expanding access department tackles revamp of medical records

'We just reorganized the way people worked'

When the director of medical records at the Philadelphia-based University of Pennsylvania Medical Center-Presbyterian left for another position, it presented yet another opportunity for the hospital's proactive patient access department to take a leadership role.

The medical records director and **Anthony M. Bruno**, MPH, MEd, director of patient access and business operations, both reported to the director of finance, he explains, so it was natural that Bruno volunteered to help fill the void the departure created, at least in the short term.

But as Bruno and his boss discussed the situation, they took the idea a step further, he adds. "We thought about the advantages of incorporating medical records into the patient access department. From an operations perspective, it seemed to have some logic."

With its processes and controls — staff training resources, its own systems analyst and solid organizational expertise — firmly in place, the access department could offer a strong base of support, Bruno explains. "We felt we could fix some [medical records] issues."

Being part of a larger department, he theorized, would allow medical records to offer more resources to tasks that it otherwise wouldn't have enough staff to accomplish.

Initially billed as interim management — "to make sure we could do what we thought we could do and to leave some wiggle room in case this was not the right direction" — Bruno and his team went to work.

The move also constitutes the latest step in Bruno's shaping of a new patient access department at Presbyterian, a process that *Hospital Access Management* has been following since soon after he joined the organization in July 2001.

Key players were **Raina Harrell**, manager of access and financial systems, and **Tanya Coleman**, a former pre-cert coordinator for oncology who was hired in November 2003 as manager for medical records, as well as Marilyn Williams, the department's systems analyst, and Lachell

Potts, its manager for quality assurance & training, Bruno says.

By late February — three months and "some new gray hairs" after the effort began — the access team was confident the new strategy was the right one, he adds.

"We just reorganized the way people work," says Harrell, noting that the success was a reflection of "the right person, the right job," one of Bruno's favorite mottos.

An immediate challenge, she notes, was notice from the state of Pennsylvania that the hospital's medical records delinquency rate — more than 50% for the month of November 2003 — was too high.

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Editorial Questions

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"Physicians are required to complete certain portions of the patient's chart," Harrell explains. "If any part is incomplete for more than 30 days after discharge, [the chart] becomes delinquent."

"We realized there was a lot we could do to make improvements," she says. "We went to work talking to physicians, talking to administrators, sending physicians weekly e-mails and pushing charts to them so they could complete them."

A report was sent each Friday to department chairmen or administrators, saying, "These charts need to be completed," Harrell adds.

Physician confidence restored

In tackling the problem, the access department was able to draw on the strong relationship it had established with the hospital's physicians, Bruno points out.

Physicians had lost confidence in the medical records department, Harrell notes, because of "things that had fallen between the cracks."

She visited medical records departments at other hospitals in the area and talked to personnel there about how their information flowed, Harrell says. "I took what worked from each department and said, 'This is what we can do.'"

One of the things she did was to reorganize the room where incomplete charts were held. The room had been organized by medical record number, Harrell says, which meant physicians had to identify themselves to a clerk, then wait for the clerk to pull the charts for them.

Now there is a box with each physician's name on it, containing the charts that need attention, she adds. "In the same box, there is also a folder for those that just need a signature. That's one of the easy fixes."

Another goal, Bruno says, was to increase consistency in monitoring uncoded inpatient and outpatient accounts. While efforts by the patient access department have dramatically reduced the number of accounts on hold in the discharge not final billed [DNFB] and outpatient exception queues, he notes, "it seemed [the medical records] piece of that project was not quite getting done."

Medical records already had an experienced staff of coders, and a clinical data coordinator overseeing them, Harrell points out, but they needed support to get records from the nursing floors in a timely manner. In addition, she says, "pieces of records lacked operative reports.

"We were able to focus the clerical staff to get

them," Harrell says. "[The existing department] had the medical records basics. Most of the staff had been here 20, 25 years, so we relied on them to know their jobs. They knew what the outcome needed to be. We helped them to get there."

With medical records working more collaboratively as a part of patient access, she adds, the process of registering the patient, obtaining the chart, getting it coded, applying charges to the account, and having the account drop off the DNFB list became "a nice continuum."

One of the issues targeted by Coleman, the new medical records manager, involved another regulatory requirement. "We found we were not meeting all the deadlines on state reporting of patients in certain diagnosis-related groups (DRGs)," she explains.

Among the 15 or so DRGs included, for example, are acute myocardial infarction and community-acquired pneumonia, Coleman adds.

The state requires not only the number of patients, but also abstracts of their medical records, Harrell points out.

"Tanya worked with the senior system analyst to run reports showing which patients meet those DRGs, and make sure the report was designed to capture all these patients," she explains.

Coleman then established a process flow for pulling the charts and getting the abstracts to the state, she adds. "Before she got started with that, she had to learn all the medical records computer systems. There is a coding system, a chart tracking system, and then you have to go into the registration system —— she had to learn all that in a very short time."

In the past, reports to the state weren't accurate, Harrell notes. "Reports weren't monitored and reviewed. As requirements changed, some DRGs (diagnosis-related groups) were included that didn't need to be, and some that were needed weren't there."

Chart turnaround reduced

Coleman, along with the clinical data coordinator and the systems analyst, went through the reports "with a fine-toothed comb," Harrell adds, eliminating some unnecessary DRGs and, in the process, reducing the costs to the hospital, which pays an outside company to abstract the reports.

One of the challenges Coleman has taken on is reducing the turnaround time for charts. "When we came in," Harrell notes, "the time it took to assemble and analyze our records, including getting them from the floor, putting them in the right order, and examining them for anything missing, was 20 days."

At last count, Coleman says, chart turnaround time was down to 48 hours. "We just needed to come together and see what we had to do to change that. [It took] offering resources to staff, getting involved, and improving communication with [nursing] floors."

The initiative required "a lot of PR work with physicians," Harrell adds. "There was some distrust there. Physicians would become delinquent after 30 days, but often would not find out there was a problem until after 20 days."

As a result of the improvements that took place during the initial three-month effort, Bruno says, the move to have patient access manage medical records is permanent. "We're getting support for additional resources down the road," he adds.

One of his recommendations, he notes, is to hire a supervisor to oversee chart completion.

While the focus of patient access is always on the revenue cycle — and the medical records initiative did make improvements there — the project presented some daunting challenges outside that realm, he points out. "We didn't know what we were getting into as far as all the other medical records requirements."

At that point, Bruno says, the commitment had been made and there was no thought of not carrying through with what resulted in "reorganizing and redesigning the entire department."

"It was a new approach for patient access," adds Harrell. "On the front end, there's patient access, medical records and clinical resource management. We've taken two of those areas and merged them, so they're working seamlessly."

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Program targets patient, physician satisfaction

Reducing LOS is another important goal

A new preadmission program at the University of California (UC) Davis Health System is building a stronger link between hospital and physician's office and identifying issues — much earlier in the process — issues that might affect

Centralized access unit is 'vision for the future'

'One-stop shop' will help physicians

As the University of California, Davis, Health System goes forward with the successful implementation of its preadmission discharge planning and utilization review program, **Karen A. Warne**, RN, manager for patient services and transfer center, keeps in mind a next step toward seamless patient access.

"My vision for the future would be that we would take the preadmission nurse and admission support and develop a centralized access unit," Warne says. This unit, she explains, would include experts in the various avenues through which patients come into the hospital, combining the expertise that lies with the ED case manager, the transfer center, and the preadmission nurse.

Bringing together this knowledge of InterQual criteria, funding and eligibility requirements, and the probable discharge needs of patients with certain indicators, Warne says, "will support our ability to be proactive."

"The glue that holds it all together," she adds, "is the nonclinical staff who make sure the patients are registered correctly, that the primary care physician is identified, and that the authorization and payer information is accurate."

This means, for example, not just identifying that the patient has a payer for the hospital stay, but looking at the patient's post-discharge care needs as well, Warne points out. "The patient might be ready for discharge and you find out there is no coverage for post-discharge care that are anticipated, or that the patient or family is not prepared for the post-discharge care needs."

Indigent patients, she adds, "are likely to have many challenges in their lives that make proactive planning extremely critical. It might be as simple as the need for transportation, or as complex as a lack of housing or lack of a support system."

Some people think they have insurance, Warne says, "but actually they have one of those $100-a-day hospital policies and are not aware they may have some financial responsibility for the services that might be needed."

Having the resources of a centralized access unit in one place, she says, "will provide a resource for physicians, who may not understand all the factors that should be considered in the transition of care between the inpatient and outpatient setting or in accepting an urgent or emergent admission or an acute transfer."

Through the development of a "one-stop shop," Warne adds, "physicians can get assistance in arranging for care in the most effective and efficient manner." ■

length of stay (LOS).

In addition to reducing LOS, the initiative is aimed at increasing patient and physician satisfaction, as well as heightening physician awareness, says **Karen Warne**, RN, manager for patient services and transfer center.

As an academic medical center and regional referral center with a large proportion of its population either nonfunded or underfunded, she notes, UC Davis gets patients who are "the sickest of the sick and the most complex of the complex."

"If we are going to improve efficiency and use of resources, we have the best opportunity to do this with our scheduled admissions," Warne explains. "We thought if we could move the energy spent once the patient is in bed, where nurses look at unidentified needs, to [a time in advance of] scheduled admissions, there would be some opportunity to work with patients proactively to identify the kinds of things they will need for a safe discharge."

"It can be as simple as understanding that the patient lives in a rural area that may be serviced in a limited way by home health," she adds, "or as complex as a patient who's homeless and normally lives under a bridge who will need intravenous antibiotics after discharge."

The patient in question might be, for example, an 80-year-old widow who lives alone, is independent, but is going to have surgery that will require not just a funding source, but family support or resources, Warne says. "Has the family been contacted? Has she been able to make arrangements [for care after discharge]? If not, what resources are available?"

Contacted before admission, before she's in

(Continued on page 43)

PRE-ADMISSION HOSPITAL DISCHARGE PLANNING QUESTIONNAIRE

Outpatient Clinic Patients expected length of stay:

Anticipated Surgery Date:

Scheduled Procedure:

Y N [1] Do you presently require assistance with activities of daily living?
(ie: shopping, bathing, dressing, cooking)

Y N [2] Do you have assistance at home following your hospital stay?

Y N [3] Do you currently reside in a facility? Name:
(ie. Board and Care, Skilled Nursing Facility, Group Home or Assisted Living)

Y N [4] Will you be going to your home following discharge?
If no, where will you be going?

Y N [5] Do you have steps to enter your home, or in your home?
steps to enter steps/stairs inside of home

Y N [6] Does your home have running water, electricity and a telephone?

Y N [7] Have you been hospitalized in the last 12 months? Where?

Y N [8] Do you have transportation home after discharge?
Who? Phone

Y N [9] Are you a caregiver for your spouse, child or other?

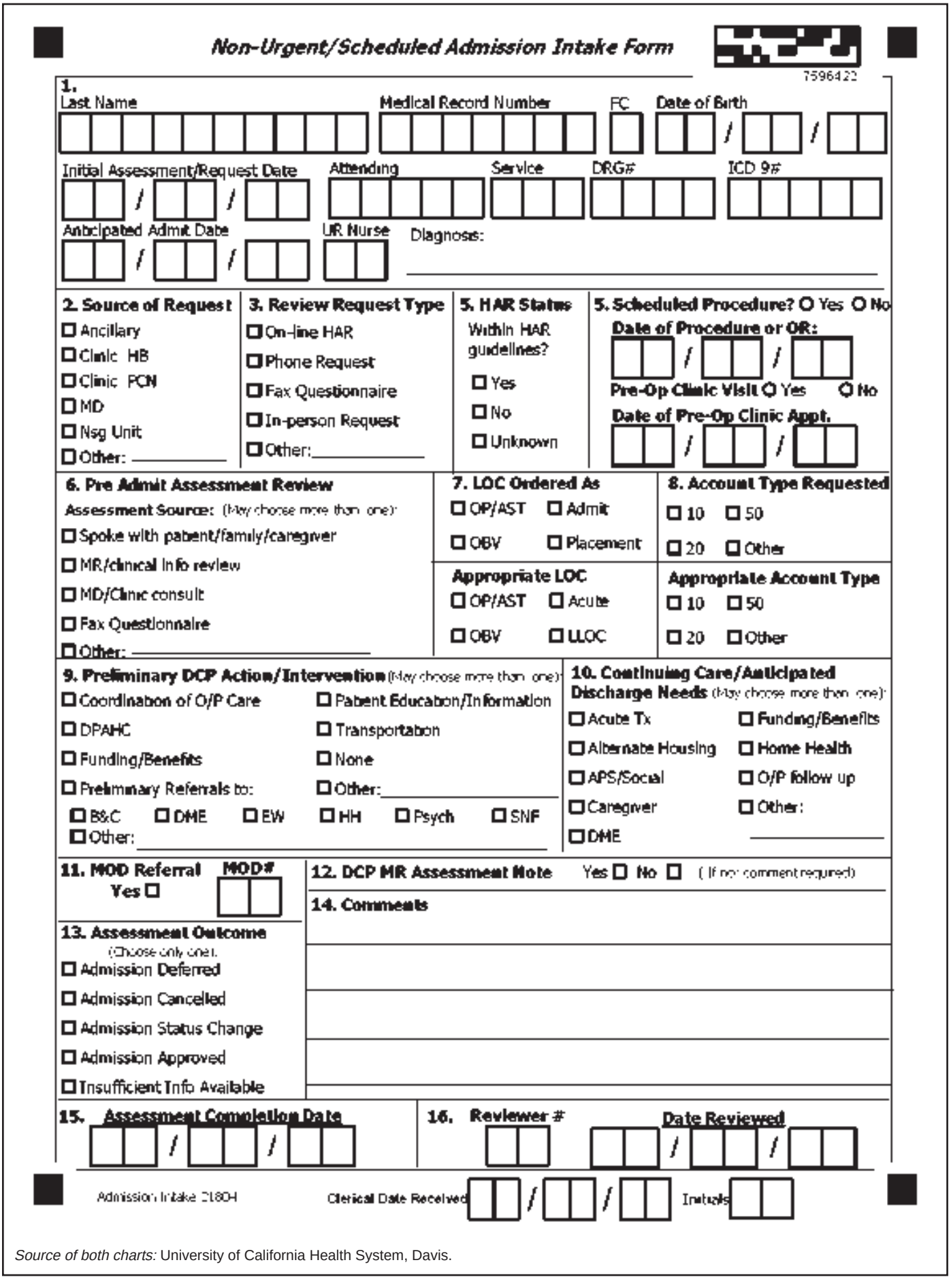
Questionnaire completed by: Date

Please add any additional concerns you may have about your discharge planning needs.

Thank you for your time in filling out this survey. You may be contacted by the Pre-Admissions Nurse Kori Pilkington, RN, to coordinate anticipated discharge needs. If you have additional questions you would like to discuss, please contact the Discharge Planning office of Patient Services at 916-734-2944.

You will have a Discharge Planner assigned to you while you are in the hospital. If you have concerns or issues regarding your discharge planning, please request that your floor nurse contact your Discharge Planner, or you can call Patient Services at 734-2944.

Fax to: Date: Copy given to patient:



Non-Urgent/Scheduled Admission Intake Form

7596422

1.
Last Name | Medical Record Number | FC | Date of Birth

Initial Assessment/Request Date | Attending | Service | DRG# | ICD 9#

Anticipated Admit Date | UR Nurse | Diagnosis:

2. Source of Request
- ☐ Ancillary
- ☐ Clinic HB
- ☐ Clinic PCN
- ☐ MD
- ☐ Nsg Unit
- ☐ Other: _____

3. Review Request Type
- ☐ On-line HAR
- ☐ Phone Request
- ☐ Fax Questionnaire
- ☐ In-person Request
- ☐ Other: _____

5. HAR Status
Within HAR guidelines?
- ☐ Yes
- ☐ No
- ☐ Unknown

5. Scheduled Procedure? ○ Yes ○ No
Date of Procedure or OR:
Pre-Op Clinic Visit ○ Yes ○ No
Date of Pre-Op Clinic Appt.

6. Pre Admit Assessment Review
Assessment Source: (May choose more than one)
- ☐ Spoke with patient/family/caregiver
- ☐ MR/clinical info review
- ☐ MD/Clinic consult
- ☐ Fax Questionnaire
- ☐ Other: _____

7. LOC Ordered As
- ☐ OP/AST ☐ Admit
- ☐ OBV ☐ Placement

Appropriate LOC
- ☐ OP/AST ☐ Acute
- ☐ OBV ☐ LLOC

8. Account Type Requested
- ☐ 10 ☐ 50
- ☐ 20 ☐ Other

Appropriate Account Type
- ☐ 10 ☐ 50
- ☐ 20 ☐ Other

9. Preliminary DCP Action/Intervention (May choose more than one)
- ☐ Coordination of O/P Care
- ☐ DPAHC
- ☐ Funding/Benefits
- ☐ Preliminary Referrals to:
  - ☐ B&C ☐ DME ☐ EW ☐ HH ☐ Psych ☐ SNF
  - ☐ Other: _____
- ☐ Patient Education/Information
- ☐ Transportation
- ☐ None
- ☐ Other: _____

10. Continuing Care/Anticipated Discharge Needs (May choose more than one)
- ☐ Acute Tx
- ☐ Alternate Housing
- ☐ APS/Social
- ☐ Caregiver
- ☐ DME
- ☐ Funding/Benefits
- ☐ Home Health
- ☐ O/P follow up
- ☐ Other: _____

11. MOD Referral Yes ☐ **MOD#**

12. DCP MR Assessment Note Yes ☐ No ☐ (If no comment required)

13. Assessment Outcome
(Choose only one)
- ☐ Admission Deferred
- ☐ Admission Cancelled
- ☐ Admission Status Change
- ☐ Admission Approved
- ☐ Insufficient Info Available

14. Comments

15. Assessment Completion Date

16. Reviewer # **Date Reviewed**

Admission Intake 2180H

Clerical Date Received / / Initials

Source of both charts: University of California Health System, Davis.

(Continued from page 40)

post-surgical pain, Warne points out, the patient is in a better position to be a participant in her own care plan.

Although no additional dollars were allocated for the program's startup in the fall of 2003, Warne says, she was allowed to designate **Kori Pilkington**, RN, one of the hospital's utilization review/discharge planning nurses, to take the new position of preadmission nurse.

"My goal is to demonstrate her value," Warne says. "A physician might be deciding to admit a patient for what really would [more appropriately] be an outpatient work-up, and Kori will be able to talk with the physician, have our physician reviewer look at the case, and a decision might be made to handle it in a more cost-effective way."

It won't take many cases of deferring elective procedures found not to be medically necessary in the acute setting, or where the patient avoided a prolonged hospital stay because discharge services were arranged in advance, to justify funds for the program, Warne suggests.

To identify patients who might be at risk for longer lengths of stay, she says, Pilkington telephones patients to ask about their post-discharge plans and their perception of what their post-discharge needs will be. She also reviews available medical records, and may speak with the physician or clinic staff. When her assessment is complete, a copy of her notes goes to the discharge planner who will have the case, as well as into the medical record, Warne adds.

Some of the clinics associated with UC Davis have collaborated with Pilkington to develop a questionnaire that patients, with a nurse's help if needed, can fill out in advance of their hospital stay, she says. The questionnaire, which includes 10 questions designed to help determine if the patient will need assistance or another level of care after discharge, then is faxed to the preadmission nurse. **(See questionnaire, p. 41.)**

The questionnaire addresses issues as simple as whether the patient has transportation from the hospital or as potentially complicated as whether the patient is a caregiver. "It's not unusual to find there is a developmentally disabled adult child at home and now the patient, who is the caregiver, has to go to a lower level of care before going home," Warne notes.

In one case, she says, clinic personnel assumed a patient would have help after discharge from the hospital because they knew she had a daughter. "It turned out the lady had told her daughter, 'Go ahead and take your vacation to Europe — it's a good time because I'm going to be laid up.'"

Another time, Warne says, a patient who lived in a trailer with no electricity asked about transportation and was told by a person at the clinic, "Oh, the discharge planner will take care of that."

"These are the kinds of things we're hoping to identify early on, shift some of the workload forward and improve communication between the outpatient and the inpatient settings," she adds. It's my observation that we operate in silos. We are working to improve the transition of care across the continuum."

In the case of the latter patient, Warne explains, Pilkington's assessment revealed that while a church group had arranged to take the person to the hospital, nothing had been planned regarding post-discharge transportation. She was able to help him contact the church to set up the return trip.

Without Pilkington's intervention, Warne notes, the discharge planner ultimately would have taken care of the problem, but the patient's discharge would have been delayed while transportation was arranged.

Another case involved a patient who was coming from a locked psychiatric facility to have surgery at the hospital, and the assumption was that the person would return to the same facility, she says. When the preadmission nurse called to confirm this, however, she learned that personnel at the psychiatric facility planned to discharge the patient, assuming they would not be able to meet his post-discharge needs.

"By [Pilkington] coming on the case early on," Warne says, "she was able to communicate with the [psychiatric patient's] conservator, identify the post-discharge needs with the surgeon, and get a nurse specialist and the psychiatric facility together to discuss the case."

"They were able to come up with a discharge destination before the patient was admitted," she notes. What otherwise might have happened, Warne says, is that hospital personnel would have assumed he was going back to the psych facility. By the time they found out differently and were able to arrange post-discharge care, she adds, much time and energy would have been expended as the patient remained in the hospital.

"It takes weeks, sometimes months, to find medical-psychiatric beds," Warne says.

In the case of another psych patient — this one coming to the hospital for cancer treatment —

Pilkington discovered that the person's family was making arrangements to move him closer to them, she says. As a result, the hospital was able to transfer care to the physician in that area who would be following the patient's long-term care.

"[The preadmission initiative] is making sure all the pieces are considered, breaking down silos by creating a flow of communication, and being able to offer expertise on some of the things the typical nurse or physician may not know," Warne adds.

Part of increasing physician awareness, she notes, is educating physicians so they are considering "non-medical things," such as funding issues and resource issues, that will affect the use of medical resources.

Pilkington, meanwhile, says one of the most enjoyable parts of her job has been interacting with the mostly elderly patients as she tries to identify their needs.

"A lot of them are delightful to talk with," she says, and appreciative of being contacted. "An orthopedic patient who was going to have a spinal fusion — a 79-year-old widow — was so thrilled. She said, 'I am so happy you called — I didn't realize UC Davis cares about me.'"

Tracking tool on the way

Although evidence of the new program's success is anecdotal at present, UC Davis is developing a tracking tool that will determine outcomes more precisely, Warne says. "[The tracking tool] is a mechanism to gather data to identify what educational initiatives we might need to consider with clinics or physicians, what the problem areas in the health system are regarding decision making in our use of resources, and hopefully, to identify patients who might benefit from having an assessment made prior to hospitalization."

In using the tool, Warne explains, the preadmission nurse will fill out an intake form that documents the outcome of her interventions and fax it into a database. **(See intake form, p. 42.)** Except for the narrative information in the "comments" part of the form, she adds, the data will fall into the various fields of the database.

"This will provide data to support the outcomes of this new program, as well as identify areas that will benefit from process improvement," she adds.

The preadmission nurse will indicate whether the patient has met InterQual criteria, used to determine the appropriateness of the admission, Warne notes. She adds, however, that the InterQual outcome is used only as a screening guideline and is not the final decision. InterQual is a clinical decision support tool produced by McKesson Health Solutions in Newton, MA. If the case doesn't meet the standardized criteria, she says, it is bumped up to a physician reviewer, who makes the final decision.

"We'll be collecting date of admission and medical record number and hope to match that with registration data to see if we're noticing a difference in overall LOS, patient satisfaction, and reimbursement," Warne says.

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ACCESS FEEDBACK

Bedside registration may be best EMTALA defense

Patient perception is key, risk officer says

Hospitals wishing to protect themselves from EMTALA-related complaints and the scrutiny follows are well advised to embrace the growing trend toward bedside registration, suggests **Peggy Nakamura**, RN, MBA, JD, assistant vice president, chief risk officer and associate counsel for Sacramento, CA-based Adventist Health.

Joining the ongoing debate regarding interpretation of the Emergency Medical Treatment and Labor Act (EMTALA) final rule that became effective Nov. 10, 2003, Nakamura points out that the language of the rule itself is not the only factor to be considered.

In the 2003 rule, the Centers for Medicare & Medicaid Services (CMS) amended the regulations to clarify that a hospital may follow reasonable registration processes for patients covered by EMTALA.

Patient registration may include requests for basic demographic information (such as name, address, and other pertinent nonfinancial information) and also may include requests for insurance

status and plan membership, as long as the inquiry does not delay the medical screening or treatment.

As further stated in the EMTALA regulations, "Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation." But while this language may seem to give access departments more leeway in registering patients than perhaps they had thought in the past, Nakamura stresses that it's important to remember that EMTALA investigations and enforcement are complaint-driven.

"That means they're only coming out and evaluating [hospital EMTALA practices] when a complaint is generated," she says. "But when they do follow up [on a complaint], it opens the door to all of the EMTALA processes."

That means investigators may look at the hospital's prior six months log of patients coming in to a dedicated emergency department (ED), and may select cases to follow through the ED experience, Nakamura notes, adding that the investigation can include interviewing patients.

What makes the complaint-driven process such a crucial factor, Nakamura continues, "is that you have to consider patient perception. That's why I believe it is difficult to defend against a patient saying, 'Once they started asking about my insurance — and I know I don't have any — I knew I better get out of there.'"

"That's discouraging the patient," she contends. "That's the position I take, because I think we have to deal with patient perception."

California hospitals, meanwhile, must adhere to a state law that is more restrictive than the federal law, she notes. "Under a health and safety code section, we in California are specifically prohibited from collecting or inquiring about financial status prior to a medical screening exam being provided."

With all this in mind, bedside registration is the way to go, Nakamura advises. "The patient is already being evaluated by the time bedside registration starts to occur," she adds. "Because they're in a bed, that's the patient perception, so you're able to [eliminate] most problems with patient perception."

HIPAA-related firings

The good news is, the access department at Community Medical Center in Fresno, CA, appears to be on top of things when it comes to ensuring compliance with the patient privacy guidelines of the Health Insurance Portability and Accountability Act (HIPAA).

The bad news, notes **Bret Kelsey**, corporate director for patient financial services, is that he already has had to terminate three employees for accessing the hospital records of fellow employees.

"We have educated and educated, so the staff know [HIPAA guidelines]," Kelsey says. "Why people think they can get away with it, I don't know. This is something we take very seriously, as any hospital should."

Complaints arose, he adds, and an investigation determined that the employees were using their access inappropriately. Other departments in the hospital have had to fire employees as well, Kelsey adds.

When it comes to handling HIPAA's transaction code set requirements, he says, "the big thing I'm waiting for from the business office perspective is more automation, more payers sending automatic remittance advice."

"The whole purpose of the transaction code is that the hospital sends a bill, [the payer] goes in and does an inquiry and sends an electronic acknowledgement," Kelsey notes. "But with some of the claims, even though we submit it to them electronically, they don't remit to us electronically."

While Medicare, Medi-Cal (Medicaid), and Blue Cross are remitting electronically, he adds, many others are not.

[Editor's note: Access professionals who would like to provide feedback on these issues or any subjects related to patient access services may contact editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.] ■

Financial aid guidelines recommended by CHA

Limit expectations, hospitals told

The California Healthcare Association (CHA) has adopted a new set of voluntary guidelines on financial aid, charity care, and discount payments for its member hospitals, including a recommendation that hospitals provide financial assistance for patients at or below 300% of the poverty level.

The guidelines focus on low-income patients and the uninsured, says CHA spokeswoman **Jan Emerson**. CHA is encouraging hospitals to limit what's expected of low-income or uninsured patients that qualify for these discounts, barring any Medicare prohibition.

The guidelines also suggest hospitals wait a minimum of 120 days before notifying collection agencies of overdue payments, work with collection agencies to develop clear policies for low-income and uninsured patients that align with the hospital's mission, and that such policies not include wage garnishments or liens on a patient's primary residence.

"To me, [the guidelines] are not really anything new," says **Bret Kelsey**, corporate director for patient financial services at Community Medical Center in Fresno, which serves a large indigent population. "A lot of those things we're already doing."

But Kelsey says he plans to stick with a financial assistance threshold of 150% of the federal poverty level — not the 300% recommended by CHA — unless mandated to do otherwise.

He notes, however, that Community Medical Center exercises leeway in its handling of financial aid, using "means testing" to make decisions, often on a case-by-case basis. A patient making as much as $50,000 a year, for example, still might qualify for help with a $300,000 hospital bill, Kelsey says.

"Some miss the charity guidelines by a few thousand dollars, but they have a $20,000 bill," he adds. "We'll look at the total picture. What is their credit history? What is their ability to make any type of payment? We might cut them a deal, say, 'Give us the [amount of the] Medicare DRG [payment].'"

Community Medical Center also offers prompt-pay discounts — typically between 10% and 20% — to patients who will settle their bill within 30 days of the discharge date, Kelsey points out. "We may increase that to 30%."

That kind of flexibility would be lost, he notes, if bill AB232 becomes law. "If it passes, [the state] is going to mandate what we can charge. I don't agree with that at all."

According to information on the Health Access California web site, www.health-access.org, the proposed legislation would:

- Require each hospital to post its policy for payment by self-pay patients.
- Require each hospital to include in the self-pay policy what is required to qualify for charity or free care.
- Limit the price paid for hospital care by low- to moderate-income self-pay to the price paid by large government payers, specifically Medicare, Medi-Cal or workers compensation.
- Require hospitals to provide the uninsured with information about Medi-Cal, Healthy Families and other programs for which the uninsured person might be eligible. ■

HHS secretary clarifies financial aid policies

Nothing prohibits discounts, AHA told

Recent guidance from the Department of Health and Human Services (HHS) recognizes that "a good-faith determination of 'financial need' may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables."

The guidance came as part of HHS Secretary **Tommy Thompson's** response to a request from American Hospital Association (AHA) president **Dick Davidson** for the government to clarify and reduce regulatory barriers that make it more difficult for hospitals to assist patients in financial need.

Confusion still exists

While hospitals in 2002 provided $22.3 billion in uncompensated care, Davidson said in a letter to Thompson, confusion about federal regulations makes it difficult for hospitals to know whether there are risks to lowering or waiving patients' bills.

In responding to Davidson's request, Thompson said in part, "Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that, as a result, the uninsured are forced to pay full price for their care."

"That suggestion is not correct," Thompson continued in the letter, "and certainly does not accurately reflect my policy. The advice you have been given regarding this issue is not consistent with my understanding of Medicare's billing rules."

To eliminate further confusion on the matter, he goes on to say, he directed the Centers for Medicare & Medicaid Services and the Office of Inspector General to prepare summaries of the policy.

"This guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations," he stated, adding, "Nothing in the Medicare program rules or regulations prohibits such discounts."

More information is available at www.hhs.gov and at www.aha.org. ■

NEWS BRIEFS

Poll indicates hospitals feeling HIPAA burnout

Some hospitals are experiencing Health Insurance Portability and Accountability Act (HIPAA) burnout as the April 21, 2005, deadline for compliance with the legislation's security rule approaches, a recent American Hospital Association (AHA) survey suggests.

A poll of AHA's 475 member health care organizations found that, while more than 40% had begun their security risk analysis, only about 25% had begun to implement the other provisions of the security rule, published in February 2003 by the Centers for Medicare & Medicaid Services (CMS).

Many hospitals still are focused on ensuring their compliance with the HIPAA electronic transactions and code set standards, and do not have the energy or resources to concentrate on the newer security standards, says **Roslyne Schulman**, an AHA senior associate director of policy development.

As a result, many hospitals are experiencing burnout, she said, adding that CMS needs to ensure that its enforcement of the security rule is consistent with the principles of flexibility and scalability laid out in the rule.

Schulman also emphasized that consistent interpretation is needed across CMS regions.

In other HIPAA news, CMS has instructed Medicare carriers and intermediaries to slow payment of electronic claims that are not compliant with the HIPAA transactions standard as an incentive to increase compliance.

CMS instructed the carriers and intermediaries to pay such "legacy" claims no earlier than 27 days after receipt instead of the current 14, beginning July 1, and called the change "a measured step toward ending the contingency plan completely." The operational change does not require regulatory approval. ▼

Charity, bad debt costs up by almost $1 billion

U.S. hospitals provided $22.3 billion in uncompensated care in 2002, up from $21.5 billion in 2001, according to the latest American Hospital Association Annual Survey of Hospitals.

The survey measure includes charity care and bad debt, valued at the cost to the hospital of the services provided.

Meanwhile, a report recently released by the Robert Wood Johnson Foundation's State Coverage Initiatives program found that states struggled to maintain or expand coverage to low-income individuals for the third consecutive year in 2003.

The ongoing struggle was attributed to the lingering budgetary crisis, increased demand for health insurance and rising health care costs.

Many states were forced to reduce benefits and eligibility for both the Medicaid program and the State Children's Health Insurance Program in 2003, the report noted.

Act provides relief

However, the federal Jobs and Growth Relief Reconciliation Act of 2003 provided some relief, providing up to $20 billion in fiscal relief for Medicaid and other programs, the authors add.

In another report on hospitals' financial problems, a preliminary analysis by the Pennsylvania Health Care Cost Containment Council revealed that 48% of the state's acute care hospitals lost money in fiscal year 2003, up from 42% in 2003 and 34% in 2001.

Carolyn Scanlan, president and CEO of the Hospital and Healthsystem of Pennsylvania, said, "High medical liability insurance costs, regulatory compliance costs, disaster preparedness costs, and persistent shortages of key health care professionals — along with historically inadequate Medicaid and Medicare reimbursements and persistently high levels of uncompensated care — will cause significant harm to our hospitals and our communities."

The council is an independent state agency that addresses health care cost and quality. ▼

COMING IN FUTURE MONTHS

- Resource web site aids admitters
- Access Career Path reaches VP level
- Bed czar gets new boss, new perspective
- Innovative customer service strategies
- Cutting-edge financial counseling

CMS quality initiative participation increasing

The number of hospitals displaying at least one of 10 quality measures on the Centers for Medicare & Medicaid Services (CMS) web site as part of a CMS quality initiative more than tripled — to 1,400 — between October 2003 and February 2004, CMS has reported.

More than 3,000 hospitals — about 75% of those eligible — have pledged to participate in the initiative. **Nancy Foster**, senior associate director of health policy for the American Hospital Association, said she expects the number will continue to rise as the web site is updated each quarter.

"This large increase is really reflective of hospitals' desire to have a solid, standardized vehicle to share information with the public," Foster said.

The CMS web site is at www.cms.gov/quality/hospital. More on the quality initiative is available at www.aha.org. ▼

ED volume increasing, most hospitals report

Some 68% of hospitals responding to a recent survey by the Schumacher Group said patient volume in their emergency department (ED) had increased in the past 12 months, with most reporting an increase from 1% to 10%.

Only 18% of respondents said overcrowding had caused them to divert patients to other hospitals, down from 36% in 2001. Seventy-six percent said a lack of coverage by physician specialists had caused them to divert patients, up from 65% who gave that response in 2001.

About 31% of respondents had lost some specialty coverage in the past year, with 33% citing uncompensated care and 26% citing medical liability concerns as factors. About half of respondents said the number of uninsured patients in their ED had increased in the past 12 months, and 77% said their ED was a major provider of primary care for the indigent and uninsured in the community.

The Schumacher Group is an ED management firm. More information is available at www.tsged.com. ■