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Access reaction is varied as government calls for discounts to uninsured patients

Some hospitals clarifying policies, educating staff

Encouragement from the Bush administration for hospitals to give discounts to uninsured patients and financially needy Medicare beneficiaries will have little impact, say some access professionals surveyed by *Hospital Access Management*, mostly because hospitals already give such discounts under the name of charity care and uncollectible bad debt.

Others say they will fine-tune their financial aid policies in view of the recent focus, while a veteran health care attorney suggests the government's announcement should be taken quite seriously by hospitals.

"This is a high-focus issue," says **Michael Taubin**, a partner in the law firm Nixon Peabody LLP in Garden City, NY, and longtime legal counsel to the Washington, DC-based National Association of Healthcare Access Management, as well as a number of individual hospital clients. "Almost every hospital I deal with is dealing with it right now."

Tommy G. Thompson, Secretary of Health and Human Services (HHS), explained the administration's position in a February letter to the American Hospital Association (AHA), which had requested a clarification of whether such discounts are permissible in view of federal fraud and abuse laws.

While hospitals in 2002 provided $22.3 billion in uncompensated care, AHA president **Dick 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."

Hospitals have come under criticism in the last two years for charging uninsured people much more than they charge people with employer-sponsored health insurance. Group health plans often negotiate rates lower than the prices charged to people without insurance.

In addition to Thompson's comments, the HHS Office of the Inspector General (OIG) offers guidance on its web site at www.oig.hhs.gov **(see related story, p. 51).**

Peter A. Kraus, CHAM, business analyst for patient accounts services

at Emory University Hospital in Atlanta, says his first response to the government's announcement is that "hospitals have always given discounts to financially needy patients under the name of charity care and uncollectible bad debt."

In addition, Kraus continues, "some hospitals offer prompt-pay discounts to uninsured or underinsured patients who pay their balances within a specified time period. Other facilities work out low or no-interest time payments with nonindigent, low-income patients who make honest efforts to pay their bills."

"In other words," he adds, "some hospitals have always practiced what the Bush administration is preaching."

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As for the HHS statement that hospitals charge self-pay patients more than insured patients, Kraus contends that such allegations are "at best, improperly phrased."

"Hospitals enter into contracts with third-party payers, Medicare included, in which they accept levels of reimbursement that are substantially less than full charges," he points out. "Contracts usually stipulate that at least a portion of the difference may not be billed to the patient, although certain agreed-upon noncovered charges or percentages can be."

"While self-pay patients don't enjoy the benefits of contractual write-offs," he adds, "neither do they generate the volume of business that allows hospitals to maintain fiscal solvency in spite of the write-offs they routinely take."

Beth Keith, CHAM, director of patient business services at Touro Infirmary in New Orleans, points out that it's important to understand that the "clarification" from Thompson is just that.

"Touro has employed the exact same principles for uninsured, underinsured, and Medicare patients for many years," she notes. "Basically, anyone who indicates a problem with paying their bill is offered the opportunity to apply for financial assistance through the hospital."

Keith's understanding of the HHS clarification, she says, is that it directs hospitals to provide almost the same options that Touro has offered for many years. "For us, this has very little impact."

At Touro Infirmary, she explains, access employees verify family size and household income, and if the income does not exceed 175% of federal poverty guidelines and the patient does not qualify for government programs, he or she is eligible for the Touro program.

"If it appears they are eligible for a government program, we ask that they complete that application process before a determination is made," Keith says. "This process is applied regardless of payer and has always been an option under the law."

Once the person is qualified, she adds, the entire bill is written off. **(See related story, p. 52.)**

Gillian Cappiello, CHAM, senior director of access services and chief privacy officer at Swedish Covenant Hospital in Chicago, says that while her hospital has always felt that it was able to offer discounts, and has done so, the new directive "does help clarify" the government's position.

"We already had written procedures for what to do if a patient is self-pay, where to guide them, but [the announcement] just raised everyone's

level of awareness," she notes. "Our reaction is that we just want to make sure that anyone walking in to the hospital knows that [financial aid] is available."

In the wake of the increased attention on discounts and charity care, Cappiello says, Swedish Covenant launched a management awareness campaign to ensure that people in need of help were directed to financial counselors.

"We wanted to make sure all of our communication was consistent, [and] that if someone says, 'I don't have insurance,' they [are] not being sent to different people, but to the professionals for whom that is their job," she adds.

After the subject was highlighted in news reports, Cappiello notes, "people were starting to call local hospitals and challenge them [regarding financial aid policies]. Our concern was that someone would call, and not everyone would know how to direct that call."

As part of that effort, she says, information on financial assistance was added to existing notices about privacy and protection of health information throughout the facility and at off-campus sites.

"What we did is [specify] that we offer assistance in paying for necessary medical services to eligible patients with limited financial means," Cappiello says, adding that the signs instruct patients to call Credit Services for additional information.

She mentioned an article in the publication *Crain's Chicago Business* and on-line at Chicago Business.com about a lawsuit alleging predatory billing practices filed in late March against another Chicago health care organization by two former uninsured patients.

"That kind of article," Cappiello adds, "is one reason we wanted to make sure we have good signage and a consistent message given to anyone inquiring about our free care and collections practices."

Taubin says his experience has been that hospitals are becoming much more attuned to the government's concern that "the uninsured be treated and not incur financial trauma as a result of hospital services."

The Hospital Association of New York has issued new guidelines for hospitals to follow in developing their financial aid policies, he notes.

"Many hospitals are looking to change their sliding scale fee schedules [to make them more generous] for patients, as well as allowing a larger class of patients to qualify," Taubin says.

OIG offers guidance on hospital discounts

In response to suggestions that two laws enforced by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) may prevent hospitals from offering discounted prices to uninsured patients. The OIG discusses each law on its web site, www.oig.hhs.gov, as follows:

"The Federal Anti-Kickback Statute. The federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a federal health care program, such as Medicare or Medicaid. The federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills.

"However, the discounts may not be linked in any manner to the generation of business payable by a federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a federal health care program.

"Section 1128(b)(6)(A) of the Social Security Act. This law permits, but does not require, the OIG to exclude from participation in the federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs — and taxpayers — from providers and suppliers that routinely charge the programs substantially more than their other customers.

"The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients." ■

"They are also carefully looking at their billing and collection processes for the uninsured, both internally and externally."

That includes, he adds, making sure that adequate controls are placed on collections agencies so that patients "are not treated with disrespect or hit with a hefty bill that is inappropriate."

Hospitals are being alerted, Taubin says, to the fact that injustices have occurred in the past. "In some cases, I know that hospitals found that — without their realizing it — [unpaid accounts] were sent to collection agencies at levels and in amounts that didn't take into context the sliding scale."

In other instances, he says, hospitals had such restrictive policies as to who would qualify for discounts that the community need was not addressed.

While agreeing that loosening financial aid guidelines could make things tougher for an already ailing hospital industry, Taubin says his advice is that "every hospital has to review its policies for charity for uninsured patients and to look to state associations for guidance as to the appropriate steps."

Kraus, meanwhile, says the bottom line on the government's stated position regarding discounts for the financially needy is that "it's really about politics."

"The Bush administration is vilifying what it hopes will be a plausible target with the voting public in order to deflect criticism that its policies do not address the growing number of uninsured in this country," he says. "Regardless of whether one thinks hospitals should do more to accommodate the needy, it is unlikely that such actions would resolve the root causes of the problem."

"In the grand scheme of things, Bush's proposal is pretty trivial," Kraus notes. "But there is always the possibility that it will take on a life of its own and make things, at least temporarily, even more uncomfortable for the beleaguered hospital industry." ■

Clinic for financially needy part of aid program

'Health insurance plan' targets working uninsured

As part of the financial aid program at the New Orleans-based Touro Infirmary, there is a clinic for uninsured or underinsured patients, says **Beth Keith**, CHAM, director of patient business services.

Patients may use the facility if family size and income do not exceed 200% of federal poverty guidelines, she explains, and are offered a 65% discount.

All other patient accounts are handled through a normal collection process, Keith adds, with four statements sent over a period of 120 days. If no response is received, those accounts are turned over to a collection agency, she notes.

"[Patients] have 90 days in which to resolve accounts that are in bad debt without being reported to a credit bureau," Keith says. "If they do not respond by that time, they are assigned to a second-level collection agency and will be reported to the credit bureau."

For the past three years, she notes, Touro Infirmary has offered a "health membership plan" for the working uninsured. After signing up for the program through the facility's marketing department, patients may receive hospital services for a 50% discount, Keith says. Some of facility's affiliated physicians offer a 25% discount to people who are signed up for the program, which is called Touro for Health, she adds.

As with an insurance company, Keith notes, the charges are discounted at the time of billing. ■

Hospitals required to offer free or discounted care

Florida, Illinois take action

At least two state legislatures have taken action in recent weeks regarding free or discounted health care services for uninsured patients, according to reports in the on-line news service, *AHA News Now.*

A Florida House committee passed legislation in late March that would require hospitals to offer a discount program for uninsured patients seeking treatment through emergency departments, but with modifications to an original proposal by the Florida Hospital Association (FHA).

The committee changed the proposed discount for qualified uninsured patients from the 30% or more proposed by FHA in January to a percentage of the Medicare payment rate.

The association was evaluating the impact of the amendment, said FHA spokesman **Rich Rasmussen**, but had concerns it would leave a

number of hospital services uncovered by the discount, since most of the uninsured treated at Florida hospitals are children and pregnant women, who may receive services not covered by the Medicare program.

Also in late March, the Hospital Charity Care Act (SB 2579) passed the Illinois Senate. It would require hospitals in the state to provide free care to uninsured patients whose income is at or below 100% of the federal poverty level, and discounted care to uninsured patients whose income is from 100% to 200% of the poverty level.

As originally proposed by the Service Employees International Union (SEIU), the bill would have required free care for the uninsured at 300% of the Medicare poverty level and discounted care at 400% of the Medicare poverty level, which would target families earning up to $75,000 per year.

The modified bill, a compromise between the Illinois Hospital Association (IHA) and SEIU, encompasses a set of charity care guidelines adopted by IHA and the Metropolitan Chicago Healthcare Council in September 2003.

To view the IHA's charity guidelines, go to www.ihatoday.org ■

Hospital increases focus on customer service

Poll highlights compassion's healing role

An "all-employee" guest-relations program at Swedish Covenant Hospital in Chicago aims to increase both the hospital's market share and its Press Ganey Associates patient satisfaction scores.

The effort began about two years ago, with a program called "Delivering the Promise" that introduced 12 service standards of excellence, reports **Gillian Cappiello**, CHAM, senior director of access services and chief privacy officer. That list of standards begins with the directive, "Make eye contact, smile, and greet each customer/employee immediately." **(See the list, p. 54.)**

"Everyone was required to attend a four-hour 'part one' training session," she adds, "and we focused on those [12 standards] throughout the session." In tandem with that training, Cappiello says, teams made up of two managers directed an initiative called "10 a day," in which they would sit down with staff for 10 minutes each day and target one of the standards. "They were responsible for creating thought-provoking exercises around those standards."

Eventually, she notes, managers were given the option of conducting the 10-minute sessions weekly, rather than daily. In addition to the 12 general service standards, Cappiello adds, there are standards adapted for each department. **(See access standards, pp. 55-56.)**

Part two of the program, which she described in late March as 70% completed, is titled "Service Recovery" and follows this "HEART" model, as in "Take the problem to heart":

- **H**ear what they have to say.
- **E**mpathize with them.
- **A**pologize for the situation.
- **R**espond to their need by . . .
- **T**aking action and following up.

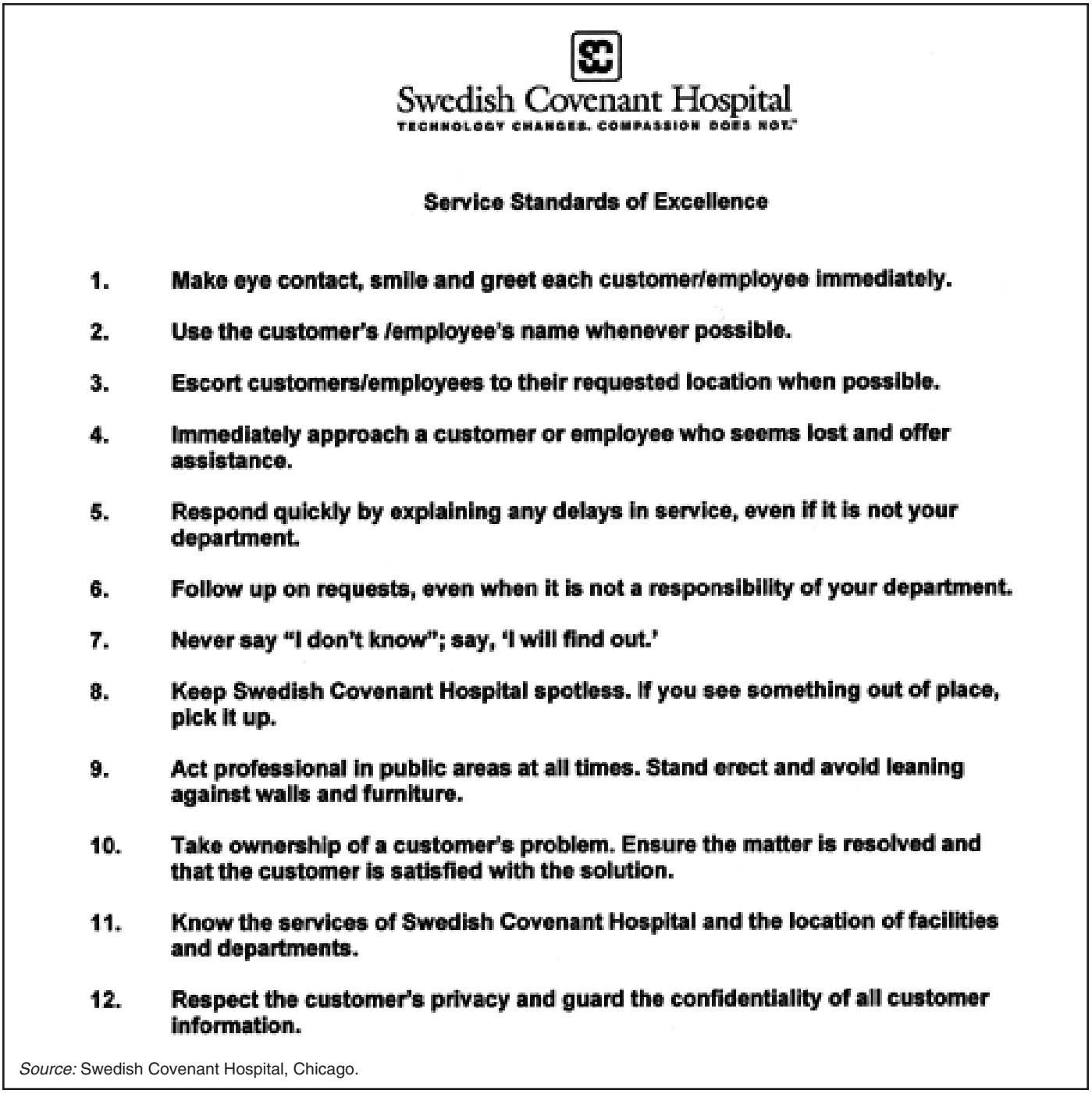
After several cycles using the service excellence standards, the focus in the "10 a day" CHECK sessions has shifted to 10 areas identified from surveys by South Bend, IN-based Press Ganey Associates as having the greatest impact in improving patient satisfaction, Cappiello says. "If you improve in these areas, it should be able to impact your score."

Those areas, as described on the survey, are:

1. **Response to concerns/complaints**
2. **Staff included you in decisions regarding treatment**
3. **Staff sensitive to inconvenience**
4. **Nurses educated regarding condition/care**
5. **Staff addressed emotional/spiritual needs**
6. **Kept informed regarding condition/treatment**
7. **Nurses kept you informed**
8. **Wait time for tests/treatments**
9. **Concern for comfort during tests/treatments**
10. **Attention to special/personal needs**

Another aspect of the program that is being rolled out is "scripting," she says. The practice is already in place in some areas, such as access services, where employees are given scripts to use when asking for copays or explaining an Advance Beneficiary Notice to Medicare patients. "In a couple of months, it is expected that all departments will have scripts to greet customers and to close a customer interaction, as well as to deal with a complaint or concern," Cappiello adds.

Employees in departments that typically respond to a large number of outside callers have received telephone customer service training, she



Swedish Covenant Hospital

TECHNOLOGY CHANGES. COMPASSION DOES NOT.

Service Standards of Excellence

1. **Make eye contact, smile and greet each customer/employee immediately.**
2. **Use the customer's /employee's name whenever possible.**
3. **Escort customers/employees to their requested location when possible.**
4. **Immediately approach a customer or employee who seems lost and offer assistance.**
5. **Respond quickly by explaining any delays in service, even if it is not your department.**
6. **Follow up on requests, even when it is not a responsibility of your department.**
7. **Never say "I don't know"; say, 'I will find out.'**
8. **Keep Swedish Covenant Hospital spotless. If you see something out of place, pick it up.**
9. **Act professional in public areas at all times. Stand erect and avoid leaning against walls and furniture.**
10. **Take ownership of a customer's problem. Ensure the matter is resolved and that the customer is satisfied with the solution.**
11. **Know the services of Swedish Covenant Hospital and the location of facilities and departments.**
12. **Respect the customer's privacy and guard the confidentiality of all customer information.**

Source: Swedish Covenant Hospital, Chicago.

notes, and have been called by secret shoppers and rated on their customer service skills.

Studying compassion

While there appears to be a fairly common belief that compassion has a positive effect on healing, Swedish Covenant Hospital recently polled a sampling of adults in its service area on Chicago's North Side to "get some numbers behind what people thought" on the subject, Cappiello says.

That study, conducted by the hospital's marketing department, found that 95% of consumers agree that compassion aids in the healing process and 88% see compassion as an important or very important aspect of health care, points out **Tim Nelson**, public relations manager.

Nearly six out of 10 survey respondents said they believe that caring behavior either speeds up the healing process or helps, and is necessary for healing, he says.

Asked about specific behaviors in the health care setting, they ranked treating patients with dignity — cited by 84% as a "very compassionate trait" — above all others, Nelson adds.

(Continued on page 57)

Swedish Covenant Hospital
TECHNOLOGY CHANGES. COMPASSION DOES NOT.

Department-Specific Guest Relations Expectations

Department: Admitting/Registration

Manager: Gillian Capiello

Please complete each section of this form with guest relations expectations and information related specifically to the department.

Department-Specific Service Standards of Excellence:
(Department standards, in addition to the 12 SCH Service Standards of Excellence).

1. Everyone should report to work with enough time to be prepared to start working at the beginning of their designated shift.

2. Greet all your co-workers with a smile and a "Good Morning/Good Afternoon" whenever you or they enter the department.

3. Let each other know when you leave the department to go for lunch, a break, or other business. This is important for safety reasons or in an emergency, or in case someone is looking for or trying to reach you.

4. When you see people waiting to register, and you are trained in registration, please assist your co-workers even before or without being asked.

5. Never let a patient who arrives in the department know if you are not expecting them. Get their name, physician's name, their reason for being here, and ask them to take a seat while you check.

6. Treat everyone the way you want to be treated, and do unto them as you would have them do unto you (e.g., If someone treats you rudely, or is unfriendly, treat them in a friendly and courteous manner).

7. Use the knowledge you have to help others — even if it's not something you usually do in your daily work. If you know it, help others and use what you know.

8. Help patients to make an appointment if they are elderly, confused, don't speak English well, or cannot read the order.

Identification of Department's Customers:

Patients
Physicians
Nursing Units

Ancillary Departments
Patient Financial Services
Emergency Department
Insurance Companies/IPA's etc.

Department Guest Relations Goals:

1. **To ensure every patient arrives at his or her destination on time/timely.**
2. **To make every patient feel welcome and that they have come to the right place.**
3. **To make sure a registration is correct and complete so the bills go to the right place and get paid.**

Guest Relations/Customer Service Measurements used by Department:

1. **Press Ganey**
2. **Letters of recommendation/STAR nomination**
3. **Exceeding on personal performance evaluation scores**

Department-Specific Telephone Standards:

1. Don't wait for someone else in the department to answer the phone. Be the first person to reach to answer the phone.

2. Always get complete information when taking a reservation or a message. Write the reservation or message legibly

3. When you receive a phone call from within the hospital asking for a coworker by name, always ask how you can help. Do not give the call to that person until you have first determined if it is something you can just as well help with.

Materials/Resources Available for Customers (i.e., brochures, patient education materials, materials in different languages, etc.):

1. **An Important Message From Medicare in English and Spanish**
2. **Advance Beneficiary Notice in English and Spanish**
3. **Appointment Center Business Cards (English and Spanish)**
4. **Physician Referral Business Cards (English and Spanish)**
5. **"About Your Bill" Collections policy brochure**

Department Service Recovery Process:

1. **Listen to the customer's concern.**
2. **Apologize for the problem/inconvenience.**
3. **Empathize with them.**
4. **Offer an explanation (not an excuse) if indicated or appropriate.**
5. **Ask what you can do to make it better, or if there is anything else you can do.**
6. **Connect then with your supervisor or manager if necessary, or if they are not satisfied with your response alone, or notify your supervisor or manager of the specific situation in case there is a trend or pattern that needs to be addressed, or if any other follow-up is needed.**

This document will become part of the department **Employee Resource Manual.**
Date: _____ 6/02; Rev. 11/02

Source: Swedish Covenant Hospital, Chicago.

(Continued from page 54)

Somewhat surprisingly, he says, when asked what professions they thought of as most compassionate, respondents put health care workers first, over clergy and social workers.

The survey results confirm that Swedish Covenant, which has historically focused strongly on providing compassionate care, is putting its emphasis in the right direction, Cappiello notes. "If our profession is seen as the most compassionate, then — while compassion is not necessarily something we can teach people — we certainly should focus on it."

[Editor's note: Gillian Cappiello can be reached at (773) 878-8200, ext. 5051, or at gcappiel@schosp.org] ■

Web site for access staff is 'day-to-day' resource

Insurance, training materials available

When access personnel at the University Hospital of Arkansas in Little Rock decided they would benefit from having their own resource web site, they sent the proposal to the information technology (IT) department, says **Holly Jones**, CHAM, a revenue integrity specialist (RIS) given the task of overseeing the project.

"We turned over to IT some documents we use frequently and some manuals we use for education," Jones adds. "Our goal was to try to put materials out there that access personnel would be able to use in their day-to-day jobs."

The idea, she explains, was that a registrar who wanted to know, for example, how to enter federal Blue Cross/Blue Shield insurance into the system or find out more about the requirements of the Emergency Medical Treatment and Labor Act, could have the information with the click of a mouse.

Jones found, however, that the IT technicians "couldn't quite grasp the formatting we were looking for" and realized she would have to take a more active role in the project than she had anticipated.

The problem had to do with "how we envisioned [the site], how accessible it would be, and the grouping we wanted things in," she says. "For instance, we have a page called "On-Line Resources" that is divided into agencies and organizations, insurance company web sites, and a whole section for Medicaid and Medicare. There is so much information [that] it was hard to explain to them how to arrange things."

Despite facing a substantial learning curve, Jones says, she "jumped in headfirst" and signed up for a class on Microsoft Front Page computer software "so I would be able to maneuver around the site and maintain it."

IT technicians "put together the background and put it on the server," she adds. "Once they set up the banner at the top of the web page, the general sections, and the tabs, what I did was gather information from the [RIS] team and post it out there."

The IT employees, meanwhile, "were there to help along the way, if I would go in and mess up a link," Jones says. "They're really great for that. Right now we're developing an accounts correction page, and they're in the process of making sure it works within our web site and that people will be able to use it."

Material already was in place

Much of the material for the web site was already in place, she notes, with most pulled from two training manuals the RIS team had put together. "We had plan code tables, and we put together an insurance verification script, so we started out posting that."

The site also includes the monthly newsletter that is specific to access personnel, with a link to past issues, Jones says, as well as information on the department's Striving Together to Achieve Results (STAR) employee recognition program, which was featured in the February 2003 issue of *Hospital Access Management.*

The Accounts Corrections page will be used, she adds, if there have been changes in a patient's pertinent registration information, such as name or insurance company. "[Registrars] can fill out a form on the computer indicating the changes, and when they click "go to e-mail," Jones says, "[the information] will be sent directly to our billing offices."

There have been several format changes to the access site, which has been in existence since July 2003, she notes, as a result of University of Arkansas Medical Sciences (UAMS) changing the look of its web site in December. "We had to make sure we were in compliance with those standards."

The resource web site is aimed at all access personnel, she says, including frontline staff, the insurance verification team, and employees known as patient representatives and point-of-service coordinators, who perform registrations although they do

not report directly to the access department.

Access to the site is not restricted, Jones adds, although some of the links and documents — including the managed care database and the insurance contracts that UAMS has with payers — are reached only through the hospital's intranet system. "Ninety percent [of the material], however, is accessible to anyone," she says.

Site reduces questions

In addition to receiving "really good feedback" on the site from staff, Jones says, she has noticed a reduction in the number of inquiries the RIS team receives, particularly regarding insurance matters. When employees do ask for help, she adds, team members refer them to the web site to encourage them to become familiar with it.

"[The site] will always be a work in progress," Jones notes. "We encourage people to let us know if they come across a web site we should link to." One suggestion prompted a link to the site for Tri-Care, the federal insurance plan for members of the military and their spouses, she adds. "It has forms and manuals on-line, so we can see what their regulations are."

Although taking care of the site has been added to her existing responsibilities — that haven't been reduced — Jones said the new task "hasn't been a burden at all."

"This is something that is really fun for me," she says. "It's something I look forward to — just knowing that I'm helping to get information out there for access personnel to utilize."

[Editor's note: Holly Jones can be reached at (501) 603-1132 or at JonesHollyR@uams.edu] ■

Web sites suggest ways to push access boundaries

'Open visiting,' patient safety highlighted

Access managers could benefit by "stretching a bit beyond their boundaries" and actively seeking participation in the clinical side of health care, suggests **Karen McKinley**, RN, CHAM, vice president of patient access and care management for Geisinger Health System in Danville, PA.

"I think we have to interact with all components of our health care system in order to do the best job we can," adds McKinley, who says that for several years, half her responsibilities have been outside the access arena. "As the cost of health care continues to grow, we can't continue to do things the way we've always done them."

"Without knowledge of what others are doing," she notes, "it's very hard to pull yourself out of the day-to-day patterns that you're in."

With that in mind, McKinley lists some web sites that she says might suggest ways to push the boundaries of access services, as well as some Geisinger initiatives that don't fit neatly into conventional health care boxes:

- **www.qualityhealthcare.org**

The web site of the Institute for Healthcare Improvement (IHI) contains information on a wide range of topics, including patient safety, patient flow, and a concept known as "open visiting" that is new to most organizations.

Among the offerings on open visiting is an article looking at Geisinger's experience with allowing family members to visit loved ones in the intensive care unit "whenever they want, for as long as they want, 24/7."

The experiment came about as the result of a challenge issued by **Donald Berwick**, IHI's president and CEO, to the hospitals enrolled in the Critical Care Settings domain of IHI's IMPACT network. IMPACT is described as "a community of change-oriented health care organizations working together to achieve new levels of quality."

In response to Berwick's plea that "at least some member hospitals execute a two-month trial of entirely open visiting in a critical care unit," Geisinger Medical Center implemented such a program "cold turkey" in August 2003.

The hospital agreed to let IHI report on the experiment's progress periodically during the next year.

- **www.clinicalmicrosystem.org**

This site, as well as the one mentioned above, "provides a broader picture of health care improvement, and offers ideas and strategies for how to change the actual delivery of health care," McKinley says. "You find an interesting perspective on how individual work units function and their contribution to the whole macrosystem."

As defined on the web site, a microsystem in health care delivery is "a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, shared information environment, and produces

performance outcomes. They evolve over time and are often embedded in larger organizations.

"As a type of complex adaptive system, they must: 1) do the work; 2) meet staff needs; and 3) maintain themselves as a clinical unit."

"Inpatient admitting, for example, would be a microsystem," McKinley explains, "as would emergency department registration. I think [the microsystem concept] gives a perspective that's a little different than teams because it actively involves patients."

The model is similar to what Geisinger did in implementing its open visiting program, bringing patients and families into the discussion of how it would be done, McKinley notes. "They said, for example, that there was not enough waiting space, that they felt crowded, and that there was difficulty getting updates on their loved ones."

"What we did," she adds, "was incorporate all of those things and incorporate limits that made sense. If you need sterility, for example, family members can't be there, so they are excused for a brief period and then allowed back in."

Stage two of the project, McKinley says, will be to involve family members in the care of the patient. "They'll be told, 'These are the things your dad has to have done every day. Which would you like to do?'"

• www.qualitymeasures.ahrq.gov

"This is a quality-measures clearinghouse," she says, "with some of the latest news on [which] measures people will have to be reporting. "[The health care industry] is moving toward more public reporting of all kinds of measures, [and] access to care or quality indicators."

A group of Wisconsin hospitals and Dartmouth-Hitchcock Medical Center have gone public with measures from their health care delivery, McKinley notes. "This [site] is sort of a connection to what's happening with measures, [and] what people are going to be accountable to do. As we get more focused on delivering error-free health care, we will all be reporting in this manner."

• www.josieking.org

This site deals with the story of a young child who died because of medical errors, she says, and in part, because hospital staff didn't listen to her mother's concerns. "Things started to go bad, and her mother saw it," McKinley adds. "It's about health care personnel not listening and actively involving families in care."

Such examples are helpful for access personnel, she notes, "because if we don't listen carefully, we do things like create duplicate medical record numbers or collect the wrong information and label things incorrectly. This could result in errors."

"We're all accountable for our piece of this complex health care puzzle," McKinley points out, "and for making sure that we pay attention to detail."

• www.iom.edu and www.jcaho.org

Geisinger has made extensive use of the web sites of the Institute of Medicine (IOM) and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in its patient safety initiatives, she says.

"They both have patient safety goals or aims, and we're using them as a foundation to build a systemwide program," McKinley adds.

The IOM's six aims contend that patient care should be patient-centered, safe, timely, efficient, effective, and equitable, she says, while JCAHO lists the following seven National Patient Safety Goals, approved in July 2002 by the organization's board of directors:

1. Improve the accuracy of patient identification.
2. Improve the effectiveness of communication among caregivers.
3. Improve the safety of using high-alert medications.
4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
5. Improve the safety of using infusion pumps.
6. Improve the effectiveness of clinical alarm systems.
7. Reduce the risk of health care-acquired infections.

The idea promulgated on both sites, she explains, is that "everybody at every level of the organization pays attention to both patient safety and staff safety."

At Geisinger, "we're trying to create an environment that is nonpunitive, [and] allows us to

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open discussions about incidents that happen," McKinley continues. "We find that most are a result of system problems, not individual problems, so we approach them from that perspective — looking for the root cause and trying to fix [it], and not blame an individual. Rarely does an individual intentionally do something wrong."

An example, she says, would be a case in which two patients on a nursing unit have the same name. A test is ordered on one patient, and somehow things get mixed up and the test is done on the wrong patient.

"Somebody made a mistake, but probably there was a series of events that allowed that to happen," McKinley says. "Did anyone take time to put a middle name on the patient's name band? Did anyone put an alert in the medical record? Did the person checking identification go through a double check?"

"It's like when you get on an airplane, the pilot goes through a massive series of checks," she notes. "The plane doesn't take off until everything is perfect. Unfortunately, in health care, we don't always apply the same rigor."

[Editor's note: Karen McKinley can be reached at kmckinley@geisinger.edu] ■

NEWS BRIEF

Report highlights provider shortage

Thirty-six million Americans do not have access to basic health care because they live in communities with an acute shortage of health care providers, according to a state-by-state analysis by the Bethesda, MD-based National Association of Community Health Centers.

The study found that nearly half of the so-called "medically unserved" population have health insurance, almost half are from low-income families, and nearly two in five are members of minority groups.

Texas has the highest medically unserved population in the United States, followed by Florida, Georgia, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Tennessee, the report says. It can be found at www.nachc.com ■

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

Latest HIMSS survey shows slow compliance

Only half of respondents completed TCS testing

The latest survey of 631 providers, payers, companies, and clearinghouses by the Healthcare Information and Management Systems Society (HIMSS) indicates that as of mid-January, only half had completed testing for the Transaction and Code Standards (TCS), which standardized what information must be contained in electronic claims and how it should be transmitted.

Consultants who provide services to physicians say that even though enforcement remains complaint-driven, physicians will have an increasingly compelling incentive to comply with the law as claims that do not follow the regulations are rejected.

John Thomas, CEO of Dallas-based MedSynergies Inc., has estimated that only 15%-20% of physician claims are in compliance with the standard. He says that as accounts receivable numbers show more unpaid claims, physicians will get the message.

Karen Trudel, director of the Department of Health and Human Services (HHS) Office of HIPAA Standards, says the agency has not set a time frame for ending contingency plans.

"TCS represents an activity the magnitude of which the health care industry had never attempted before," she says. "You've got so many different moving parts that a lot of people underestimated the complexity of the process." She estimates that two-thirds of Medicare claims being received by HHS are compliant.

More culture than technology

HIMSS officials say the stumbling block for providers is more culture than technology. Many delays, they say, simply relate to the fact that physicians have many demands on their times that they assign a higher priority than technology.

"With any systems upgrade, the technology is probably the easiest part, and culture change the most difficult part," says **Joyce Sensmeier**, director of professional services at HIMSS.

The HIMSS survey showed that while 45% of providers and 56% of payers were ready to accept or transmit the standardized transactions, only 40% of the companies that make software for the industry were prepared. That was down from an earlier survey in which 47% of the companies reported they were ready to handle the transactions.

The consulting firm Frost & Sullivan has estimated that providers such as hospitals, managed care organizations, and physicians have spent $1.2 billion on HIPAA.

Apparently, most of that spending was by organizations characterized as early adopters, especially large organizations with the resources available to use for experimenting with new initiatives.

But most physicians practice in small groups; approximately two-thirds of all physicians are in group practices of eight or fewer members, and they may have only recently installed a computer and assigned information technology duties to the office manager. Thus, they're dragging their feet on coming into compliance with transaction and code standards, even as the deadline for compliance with security requirements is only 12 months away.

Security standards

The security standards require health care groups to assess their systems' susceptibility to unauthorized access and put a policy in place to deal with that concern. Trudel says the security standards may not pose as much of a problem as TCS because of flexibility built into the requirements. "We're saying you have to think about your risk and how you can best mitigate that risk," she said. "But a lot of people are going to be asking us to tell them exactly what they have to do." ■

Workgroup urges patience on HIPAA compliance

Entities making 'good-faith effort,' WEDI says

The Workgroup for Electronic Data Interchange (WEDI), which advises the Department of Health and Human Services (HHS) on issues related to administrative simplification under HIPAA, says the agency should show continued patience as covered entities continue to make progress in implementation of the HIPAA transactions and code sets (TCS) requirements.

WEDI chairman **Ed Jones** gave HHS Secretary Tommy Thompson results of a December 2003 session at which WEDI took testimony on TCS standards implementation status, data content requirements, and implementation sequencing.

In general, Jones said in a March 8 letter, hearing testimony indicated that:

1. Covered entities are making good-faith efforts to move toward standard claim compliance under HHS' July 2003 contingency guidelines.
2. HHS guidance to implement contingency plans has helped ease the transition.
3. Most covered entities are focusing on implementing compliant claims rather than on other TCS standards.
4. Cost benefit from TCS has not been fully realized.
5. A small number of large payers and providers account for a large but unknown volume of compliant transactions.
6. A large but unknown number of covered entities have not yet achieved TCS standards compliance with their trading partners because of difficulties in completing testing with them.
7. Payment disruptions to providers, providers dropping claims to paper instead of sending noncompliant electronic transactions, and health plans rejecting noncompliant claims have occurred during the transition.
8. Covered entities are experiencing some data content challenges that require further guidance from the federal government.
9. Covered entities need rapid deployment of standard provider and health plan identifiers to achieve interoperability.

Based on that testimony, WEDI made recommendations in four areas — continue the HHS policy of allowing contingency plans, enhance the implementation process, revise and enhance the standards development process, and validate costs and benefits of TCS implementation.

WEDI says it recommends HHS continue its contingency plans with an emphasis on moving health plans and clearinghouses into full compliance while providers complete testing and implementation. Until a number of issues identified in the December testimony are resolved, the organization says, covered entities only may be able to implement the standard format without supplying all of the required data content.

To enhance the implementation process, a major consensus that emerged in the testimony is that the TCS implementation is trying to do too much at one time. "For example," the WEDI letter says, "the current TCS rule mandated several transactions at one time, even though each transaction represented a significant amount of effort. Claims status, eligibility, and authorization/referral can be separated from the claim and payment transactions and implemented on unique timelines."

WEDI recommended that future rules consider and establish realistic timelines for completing all required actions for successful implementation. If it appears that an implementation can't be accomplished in a reasonable period, it says, the implementation should be divided into component parts that can be completed separately.

WEDI also supports the concept of a staged implementation and recommends that software vendors be considered in staging, since most providers, payers, and clearinghouses use translators and other purchased software and are unable to be ready without availability of compliant software.

Revision and enhancement of the standards development process could be helped by reaching out for provider input in the standards development process, WEDI says. Also, business decision makers should be encouraged to participate in standards development.

According to the WEDI letter, the cost of implementing the HIPAA TCS has exceeded industry expectations. It recommends that realistic cost and benefit studies be conducted to validate proposed savings and encourage industry movement toward cost-effective solutions.

It also recommends that HHS schedule follow-up studies to determine the effectiveness of the implementation, and that the health care industry continue to identify ongoing opportunities to drive costs from the systems and simplify administration of the health care system. ■

Researchers: HIPAA may hurt outcomes studies

Rules affect ability to follow patients post-discharge

University of Michigan (UM) researchers said at the annual scientific session of the American College of Cardiology held March 7-10 in New Orleans that HIPAA has significantly affected their ability to study heart attack patients after they are discharged from the hospital.

Long-term outcome studies are crucial for evaluating medical care, such as the number of patients who die or have complications after surgery or hospitalization. But HIPAA requires written authorization from a patient before he or she can be contacted to gather personal health information for a research study. Before HIPAA, UM researchers used a verbal privacy authorization they obtained when they called patients at home months after they left the hospital.

They reported that when they switched from the verbal OK to a HIPAA-compliant written authorization that had to be mailed to patients and mailed back, there was a significant reduction in the percentage of patients consenting to be called, down from 96.1% to 38.5%. As a result, they said, the consented population was not representative of the entire population of patients the researchers wanted to study, and that could bias the study results.

"On top of the impact on the quality of the data, the costs involved in asking for the written authorization were substantially larger than those for the verbal system," said researcher **Eva Kline-Rogers**. "To get consent from one patient, we calculated we'd spend $14.50 per patient in the first year of the study for computer, training, staff, administrative, and mailing costs, and $7.50 each year afterward." She says that asking patients for consent while they still are in the hospital to avoid the mailing costs would be labor-intensive and cost-prohibitive.

"The balance between protecting patient privacy, while at the same time we strive to learn about the best methods by which to treat patients after certain types of conditions and/or treatments is delicate," said study senior author **Kim Eagle**, MD, clinical director of the UM cardiovascular center. "If long-term patient outcomes are to be used to 'inform' current care, we must develop better ways of working with patients and regulatory agencies to define the proper balance."

Kline-Rogers said she and her colleagues set out to obtain written consent from heart patients six months after they left the university hospital after being treated for acute coronary syndrome — either a heart attack or unstable angina episode. They got the list of patients retrospectively by reviewing discharge diagnoses for each patient, which is allowed under HIPAA as part of a research study.

Between Sept. 1, 2001, and March 31, 2003, the researchers sent letters and consent forms to the patients, and followed up with phone calls to those who responded to ask questions about their health.

Because the HIPAA compliance mandate was not fully operational at the time of the study, they also were able to call patients who did mail back an authorization form to try to obtain verbal consent.

In addition to the drop in authorizations, researchers found that those who returned the HIPAA-compliant written consent were more likely to be older, married, or to have high blood cholesterol than those who didn't. They also were less likely to be widowed.

There also was a significant difference in the ability to receive consent from a spouse or authorized relative to obtain information on patients who had died. Some 10% of the patients in the group where contact was made verbally or records were searched had died, vs. 3.3% of the group contacted for written consent.

"HIPAA compliance will challenge researchers, institutions, and ultimately patients as we try to learn about the outcomes of health care while trying to maintain patient privacy," Eagle said. ■

Possible incentive for physician compliance

Reduced premiums could boost compliance

A security consulting firm that is providing security risk assessment and compliance review services for small health care related businesses says one way to increase incentives for physicians to come into compliance with HIPAA requirements would be for malpractice insurers to offer reduced premiums to those who have done a risk assessment and are moving forward on implementation.

Robert Aanerud, chief risk officer at St. Paul, MN-based HotSkills Inc., tells *HIPAA Regulatory*

Alert there is precedent for such a move in the financial services field and other market segments, and he expects it to be offered by medical malpractice insurers within a year or so.

"I'm in discussions with several insurance companies," he says. "There are several insurers already offering that type of discount on professional liability insurance in the financial services and other fields."

That type of incentive, Aanerud says, is going to be important to get physicians and physician groups to think in terms of assessing their compliance level and moving forward.

He notes that many firms implementing compliance initiatives are too focused on technology, and many of those assessments don't go far enough. Aanerud says his company is using a holistic, quality-based ISO standards approach that addresses all aspects of business risk, including physical, technical, personnel, and procedural.

"We involve the organization's management team in this process to ensure they understand the business risks, and then they determine the degree of risk they're willing to accept," he says. "Management's involvement is a necessary and often overlooked measure to building a defensible security management program."

Some ignoring obligations

According to Aanerud, ISO17799/BS7799 is a management-driven process that can be implemented by businesses of all sizes. "Certification for information security can provide businesses with many competitive and operational advantages, including increased trust and credibility with customers, stakeholders, and business partners; more effective operations in other countries that use these standards; and reduced liability risk, which may result in lower business insurance premiums."

Aanerud says his sense is that many physicians and physician networks still are ignoring their obligation to comply with HIPAA. "Sometimes they're in denial about whether it applies to them or really will be enforced," he says. "They also often don't understand the requirements, don't yet see the risk to themselves in not complying with the requirements, and are more concerned about patient care than complying with HIPAA standards."

Aanerud says the April 2005 deadline is creating a false sense of security because "businesses that release personal information can be liable right now for the complete scope of this regulation if they have not shown intent to protect that information." He says the first step in proactively addressing the standards is to conduct an overview risk assessment that, for many physician organizations, can take one to two days.

The fact that enforcement by the Department of Health and Human Services (HHS) currently is complaint-driven also is encouraging the false sense of security, Aanerud says. "HHS hasn't yet identified the agencies that are going to perform compliance reviews," he says. "The need to comply with the requirements isn't going to become real to many people until they do that. People have to see that the 'HIPAA cops' are coming. But I think it's going to be quite a while until the agency acts."

In the meantime, Aanerud and other consultants are urging covered entities to take their obligations seriously, perform a risk assessment so they will have a good sense of the gaps they are facing and the costs to address them, and then move into implementation.

For example, the Information Technology Solution Providers Alliance, a national organization established to help the nation's small to medium businesses understand how local technology providers can help them, is devoting a lot of energy to HIPAA and offers the following tips for complying with the regulations:

- **Provide** employee reviews and give all employees an opportunity to review and change, if necessary, their protected health information.
- **Distribute** privacy notices that spell out HIPAA requirements for all employees.
- **Update** health care documents to reflect current HIPAA regulations regarding permissible uses and disclosures of protected health information.
- **Put** safeguards in place, such as assigning someone the responsibility of handling privacy issues and establishing methods for handling complaints.
- **Work** with service providers to establish agreements with outside companies that help administer the organization's health plan to ensure compliance with privacy rules.
- **Train** employees in HIPAA privacy rules.
- **Lock up** records and files that contain employee health care information, and use computer passwords and firewalls to protect on-line information.
- **Increase** computer security features.
- **Ask** an information technology solution provider for assistance. ■