Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

JUNE 2004
VOL. 23, NO. 6 • (pages 61-72)

Increased spotlight on self-pay gives financial counseling an overhaul

Successful move from business office to access department

Higher patient copays and increasing numbers of people who are working but not insured have made the management of self-pay accounts a more crucial issue than ever for most of the nation's hospitals.

With that in mind, OhioHealth has taken a hard look at providing better service for patients and streamlining financial counseling practices across the board at its Columbus-based hospitals, says **Marne Bonomo**, PhD, corporate director for patient access. Most notably, the company made the decision to move financial counseling from the business office to the point of service — the access department.

With a change occurring in the management of the business office and a business consultant on-site, the timing was good, notes Bonomo, who assumed her position with OhioHealth in September 2003.

As she sought ways to enhance management of the revenue cycle, an immediate concern was that the financial counseling process was not consistent across the organization, she explains. "It was different on all three hospital campuses and at a key ambulatory clinic whose staff report to access. One financial counselor would start with a patient and might or might not finish the episode. [He or she] might hand off to a financial counselor in the central pre-registration/verification group or to one at the registration site."

Because the reporting procedures were not the same, Bonomo adds, it was difficult to know when the work on an account was truly finished. Under the new plan, she says, "The [person] who starts the process will finish it, carrying through until the patient is either approved for a government program or charity, or until payment arrangements are made."

Another issue, Bonomo notes, was staffing at the system's largest Columbus-area hospital had dwindled to three or four financial counselors who had not had a manager for more than a year. "We wanted to make sure they had the training and the tools they needed."

A third-party vendor, meanwhile, had been assisting OhioHealth in

account management, she adds, but the services provided were not the same throughout the system. In some cases, for example, the vendor might find out if the patient had insurance, and then bump the account back to the hospital, while in others the hospital staff would hand off accounts they felt they couldn't handle to the vendor, but were not triaging them in the same way.

The different hospitals had different contracts that handled different parts of the process, Bonomo says. Without a uniform contract with one set of prices, she adds, it is difficult to determine if any financial counseling initiative was beneficial.

In January 2004, Bonomo continues, OhioHealth contacted the vendor to "sit down and think about what we might do," and 90 days later — in early April — implementation began at the beta site at the health system's inner-city hospital, Grant Medical Center.

"Our strongest staff are there; they're already providing clean, consistent reports," she says. "As we get our process working there, we will roll out to the other two hospitals and the clinic."

One of the benefits of the financial counseling initiative, notes **Michael Armintrout**, Grant Medical Center's director of patient access, is that it has created a front-end unity between registrars and financial counselors. "Both areas now have the same focus — to get a payer source for the patient," he adds.

There was much preparation, albeit in a short time frame, Bonomo says. "We looked across all of the campuses and flowcharted our self-pay management process. [Then we] came up with best practice and decided that would be what we would do. We would make sure we were compliant with government regulations and with [the system's philosophy of] customer service, as well as being efficient."

OhioHealth is very focused on customer service, Bonomo says. The company measures its patient satisfaction results against those of the other clients of the South Bend, IN-based firm, Press Ganey Associates, and makes patient satisfaction a priority in all decisions.

The speed with which the financial counseling initiative was implemented and the accountability that was built into the process reflects the way OhioHealth operates, she notes. What is new and different, Bonomo points out, is that for the first time accountability for results has been moved from the business office to access services. "In the past, self-pay management hadn't been a big accountability for patient access." **(See "How to Improve Account Management" on p. 63.)**

Some positions were in the process of being filled, she says, but among the three hospitals, there are approximately 25 financial counselors. "I don't know how many people the vendor will need, but [the company] made a commitment to take up the slack."

For the first time, Bonomo says, the vendor will provide "full service," meaning its staff will take the accounts they are assigned all the way through to resolution.

"My staff will triage all of the self-pay accounts and hand off what we can't handle to the vendor," she notes. "The vendor will handle [the

Hospital Access Management™ (ISSN 1079-0365) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $479. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $383 per year; 10 to 20 additional copies, $287 per year; for more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

Call **Jayne B. Gaskins** at (404) 262-5406.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Lila Margaret Moore**, (520) 299-8730.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jayne B. Gaskins**, (404) 262-5406, (jayne.gaskins@thomson.com).
Senior Production Editor: **Nancy McCreary**.

How to Improve Account Management

- Provide full-service financial counseling for inpatients, observation, and outpatients >$1K, or outpatients with multiple accounts (includes program approvals, payment arrangements and insurance finds)
- Eliminate account handoffs from vendor to financial counselors, to PRVC, to Patient Accounts, to vendor
- Use best practice self-pay management procedures, flowcharted for Patient Access and for vendor
- Back-fill OhioHealth staffing resources with vendor
- Manage all account handoffs to vendor
- Stop patient shopping. Single self-pay discount policy followed by all entities
- Financial counselors monitor account quality for all Patient Access and vendor accounts
- Handoffs to vendor include: out-of-county patients, disabilities, illegal aliens, discharged patients, nights/weekends/emergency department patients that we currently miss, and all accounts still needing work after 45 days
- All vendor contracts summarized into one OhioHealth document
- Standardized eligibility pricing for all facilities
- OhioHealth to "Authorization to Represent" documents signed at registration
- Weekly/monthly meetings and reports from vendor
- Quarterly review of vendor pricing structure written into contract
- Expected results — overall net patient revenue increase through qualification of Medicaid or HCAP/Charity

Source: OhioHealth, Columbus, OH.

accounts of] discharged patients, out-of-county patients, those with disabilities, illegal aliens, nights/weekend/ED patients that we currently miss, and all accounts still needing work after 45 days." **(See ED handoff process, p. 64.)**

In the past, Bonomo explains, hospital staff might have held onto an account too long or missed an account altogether because patients from areas such as outpatient services or the emergency department (ED) were there for such a short time. "We weren't catching the ED volume and the outpatient high-dollar procedures."

To address such problems, she says, in addition to augmenting with vendor services, financial counselors have been moved into the ED.

In other instances, Bonomo adds, work on an account might have been finished, but staff didn't realize it and handed it off to the vendor when there was nothing further that could be done.

"If [we do] everything we [can] and it's just held up at the county for approval," she says, "it's no good to hand it over to the vendor. But if someone needs to knock on the patient's door, get more information, then it makes sense to give it to the vendor."

Customer service essential

One of Bonomo's primary goals, she emphasizes, is to ensure that there is every opportunity to get the bill paid before the account — or the patient — leaves the hospital. "I want my staff handling what is in-house," she adds. "I don't want to disrupt customer service by being perceived as being unfriendly or pushy . . . or by letting them out the door and saying, 'Oh, well, it's a self-pay.'"

OhioHealth will monitor the vendor's service level closely, Bonomo notes, comparing it against the service provided by the hospital's own staff by using a patient survey. "We won't be able to survey every patient, as we do [in-house], but we will pick a big enough random sample that we get a true feeling."

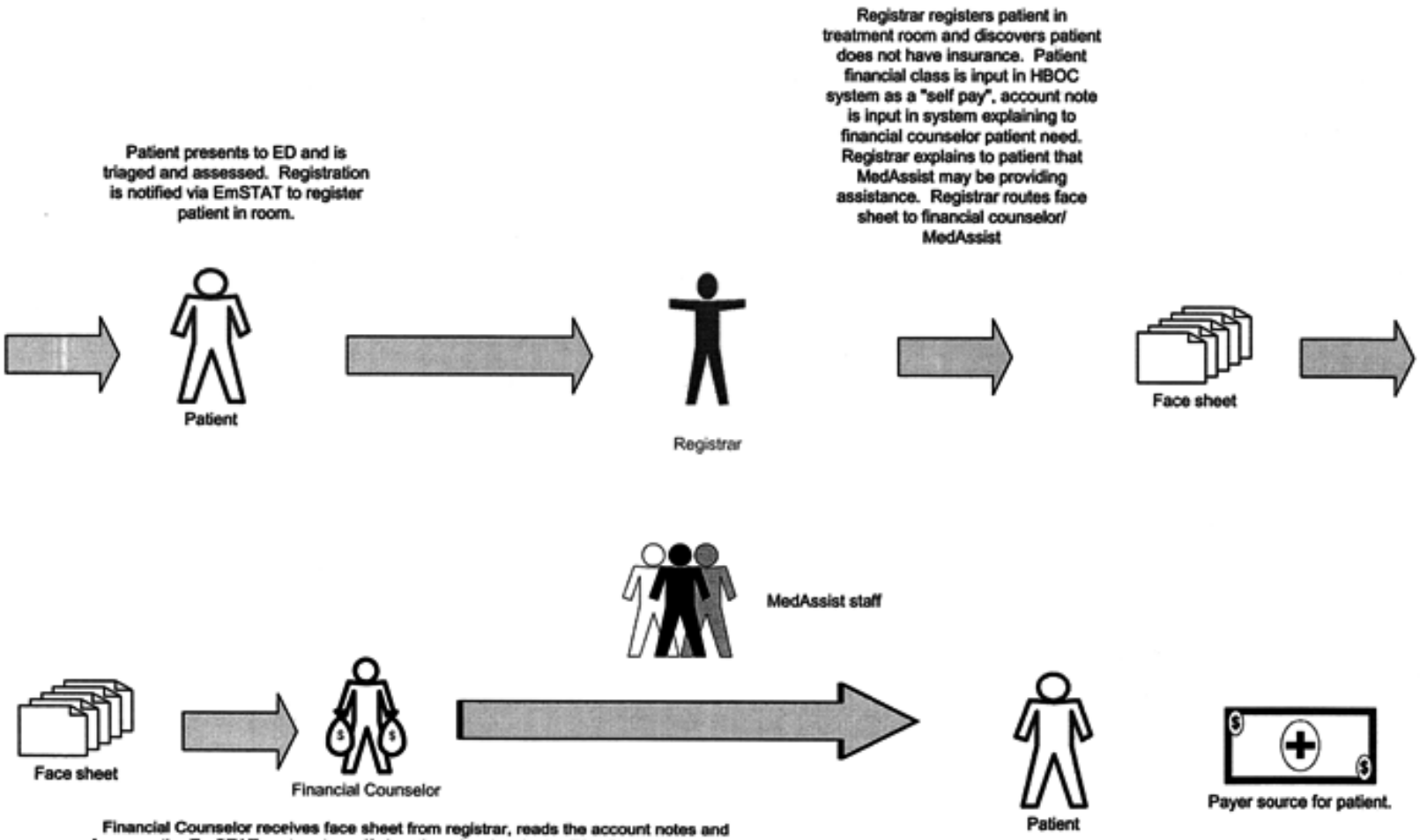
The full-service arrangement represents a new way of doing things for the vendor, she says, and if the program is successful, it will be something the company can use with other clients.

The idea is to capitalize on the expertise of the health system's own financial counselors, Bonomo says. "We want to augment that — not disrupt what we already [have]. Over time, if we're able to do more with our own staff, we will do that, but this is an opportunity for the vendor now to have more business than it has had."

Something else that Bonomo's staff — specifically Armintrout's team at Grant Medical Center — has developed is a quality tool for financial counseling, with codes that go into the computer system for each part of the process, she explains. "We get a report so that we know if they're doing everything they're supposed to do on an account. No one had done that before with financial counseling."

(Continued on page 65)

REGISTRAR/FINANCIAL COUNSELOR HAND OFF IN EMERGENCY DEPARTMENT AT GMC



Source: OhioHealth, Columbus, OH.

[Editor's note: Marne Bonomo may be reached at (614) 566-4128 or by e-mail at MBONOMO@OhioHealth.com] ■

Report card provides staff feedback at a glance

Customer service, quality ratings included

A new registration report card at Children's Health Care of Atlanta provides access managers with key information on the performance of individual employees in a convenient, easy to read format.

Much of the data was available before, but getting to it was a tedious process, says **Millie Brown**, director of patient access. The monthly report card, she adds, allows her to see, at a glance, how access employees are doing in five important categories.

One measurement given on the report card, she says, comes from information gleaned from the hospital's Press Ganey Associates patient satisfaction surveys. Although many hospitals are clients of the South Bend, IN-based firm, some may not be taking advantage of the opportunity to get back employee-specific reports on the data contained in surveys sent to Press Ganey, Brown notes.

Most hospitals look at performance by department, receiving results based on averaging the survey data, she adds. "So you get a score for the department, but you're not able to get to the individual [performance]."

But Brown points out that "Press Ganey is able to [give back] any information we provide to them in a data file."

Even though the firm doesn't need the patient account number that corresponds to each patient survey, she explains, Children's Health Care includes that number, as well as the initials of the registrar whose service the survey reflects.

"That way, when we get back the data that are attached to the survey outcomes, we're able to sort that data and compile [results] according to employee," she says.

Otherwise, Brown says, unless a patient happened to mention the person in the survey, "you'd have to look it up — it would be lots of trouble" to get the feedback on an individual employee.

Depending on department, she notes, there are three or four survey questions that relate directly to the employee's performance: "What was the wait time to register? Was the registrar friendly and courteous? Was the environment pleasant and clean?"

"I want to reward consistent behavior," Brown says, and not focus on an isolated positive report on a particular employee. "I might have a registrar that got five surveys back, with one glowing report and five bad ones. I want to acknowledge that you did [a good job] this time, but reward that you do it all the time."

With the individual data she has been obtaining through Press Ganey for more than a year, Brown says she has been able to look at an employee's performance during that time frame. What just came together in April 2004, she adds, is the electronic process that takes that data, organizes it, and presents it in the neat monthly package that she has dubbed the registration "report card." **(See the Report Card, p. 66.)**

In addition to the Press Ganey customer service information, Brown explains, the report card includes four other measures:

1. **Quality.** This figure is the result of random quality checks of registrations throughout the month. Registrars are expected to have an accuracy rate of 90% or greater.
2. **Denials.** The number and the dollar amount of claims that are denied due to errors the registrar could have corrected are included.
3. **Productivity.** This measurement reflects the number of registrations completed by the registrar. Depending on volume and area, the goals are based on each registrar doing his or her share.
4. **POS collections.** This figure is the amount of money the registrar is responsible for collecting at the point of service.

"This is the first month we've had the report card completed like we want it," reports Brown, adding that she worked closely with the hospital's information systems and technology (IST) department to develop the process. "We worked with them throughout it. They were excited to do it."

In addition to the individual report cards, Brown explains, she receives one with the registrars' results combined according to who their supervisor is, and one that organizes the results by manager.

Scores from the report cards are used for training purposes, for identifying top performers, and

(Continued on page 67)

Patient Access

Registrar: **Month:**

Monthly Score Card

	Your Score	Goal
Customer Service:		_____
Fatal Quality:		_____
Productivity:		_____
POS% *(if applicable)*		_____
Denial Total Accts:		_____
Denial Total Dollars:		_____

Action Plan: For any scores below 85% for quality and denial should complete the following:

Step 1 - Shadow a High-Performing Peer _____

Step 2 - Attend the Insurance Card Class: _____

Step 3 - Insurance Card Re-test: _____

Other Comments:

_____

_____

_____

_____

Source: Children's Healthcare of Atlanta.

are rolled into employees' annual job evaluations, Brown says.

The report cards also will be used to help determine winners in the department's annual "Patient Access Awards" — styled after the Academy Awards — which are presented in a ceremony held each October, just after the end of the organization's fiscal year, she adds.

"We give awards to everyone who meets the criteria in all the given categories," Brown says. "There is a goal for each category — top POS collections, lowest denial rate, etc. — and we rate each employee with a 1, 2, 3, or 4," depending on whether he or she simply "meets expectations" or attains a higher mark.

Patient access awards go to the registrar who is at the top of each category and to the top overall performer, Brown adds. "There are also other awards, like gold medals for those who score over 95% in quality."

"The award ceremony last year was awesome," she notes. "The staff loved it, and my vice president said it was the best staff meeting he had ever seen, because everybody came back to work so motivated to do more."

The top performer received a surround-sound stereo system, Brown says, which she paid for with the funds usually spent doling out small rewards throughout the year. "When she saw she had won [the stereo], that was it," she adds. "Everybody is determined to win next time."

While Brown's access staff at Children's totals about 150 people, she says the number of employees participating in the awards ceremony will grow to between 220 and 300 next year when it expands systemwide to include two hospitals and numerous satellite clinics.

At that point, Brown says, individual awards will be given by hospital, but there will still be one overall winner.

The wizard that appears at the top of the report card is the department's training mascot, she points out. "He's on everything that we do in that area, which makes the item instantly recognizable as having to do with training."

On Halloween, Brown and the training manager dress as wizards, and employees have to correctly answer a training-related question to get candy, she adds. "We have fun with it."

[Editor's note: Millie Brown can be reached at (404) 929-7514 or by e-mail (millie.brown@choa.org). Look for an article in the next issue of Hospital Access Management *on the strategies she used to get coverage for 90% of the hospital's self-pay patients.]* ■

Career Paths

Focus on eligibility work becomes career keystone

Networking, CM expertise important

You don't always know which experiences might prove beneficial when it comes to building a successful career in access services.

Although **Patti Daniel**, MS, CCM, LPC, LMSW/AP, never planned or expected to become the director of admissions at a 1,000-bed regional medical center, expertise gleaned from several positions early in her career serendipitously laid the perfect groundwork for the job.

Just out of college with a degree in social work and rehabilitation, Daniel says, she used an employment agency to get a job in the claims department of a Dallas insurance company. "I had never lived in Dallas before and didn't have a network built up [to find a position in the social work field]," she explains.

Networking skills established early

Skills she acquired during the six months she worked for the insurance company, Daniel adds, served her well in all her subsequent positions, including the access director job. Her knack for network building was initially fostered when she accepted a job at Dallas County Human Services, an agency that provided temporary emergency assistance. She discovered this opportunity through the recommendation of the church pastor while serving as a volunteer church youth counselor.

"They didn't have a social work position, but there was a secretary job open, so I took it," she notes. Within six months, Daniel had become a field social worker, making home visits and helping to meet families' basic needs.

"One of our goals was to get the person off the Dallas County tax rolls and put them onto a permanent benefit program, if eligible," Daniel says. "There was no training at all other than how to give a food voucher."

On her own initiative, she says, Daniel went to

every agency that might provide funding or resources for her clients and "learned everything about them." That knowledge — of programs such as Medicaid, Medicare, Social Security and SSI (Supplemental Security Income), Kidney Health, Crime Victims Assistance, and others — has proved invaluable in every subsequent job she has held, Daniel notes.

When clients needed an advocate, she often represented them in place of an attorney, she says, arguing before an administrative law judge at disability hearings.

Daniel was rewarded for her proactive approach, she adds wryly, by getting "all the really hard assignments." She was given the job of emergency social worker, where she responded to calls such as those in which an elderly person had been evicted, with his or her belongings on the curb.

"Within the day, I had to find a place to move them to, find someone to move them, and get utilities and food set up," Daniel says. "I couldn't do that without networking, so I started building a network early in my career, and learned how valuable they were."

During her tenure with the temporary assistance agency, Daniel adds, she became its unofficial training coordinator, bringing in speakers to talk with staff about eligibility programs. After five years, she became the supervisor, overseeing employees who made the home visits.

"I learned not only the benefit programs, but a lot of medical information," Daniel notes, "like how long a person would be disabled because of certain conditions — whether six or eight weeks with a broken leg, or with something more serious for a lifetime. I had to know which program would be right for each person. That knowledge has been valuable throughout my career and is to this day."

Expanding on networking skills

Daniel spent the next 20 years of her career in positions associated with Parkland Health and Hospital System in Dallas, first as director of the Access Center for the Elderly, serving as "the glue that kept the providers in the aging network working together to serve the needs of the elderly."

Again, she drew from, and expanded on, her expertise in networking and benefits programs, Daniel explains. "The network I coordinated represented 55 public and private health and human services agencies," she adds. "It was a case management program where, on a weekly basis, we would discuss the programs and talk about getting [people's] needs met."

Daniel's next job in the health care system was as a program director for Out of County Case Management where the focus on eligibility took a different twist, she notes. That program's goal was to identify patients who were not county residents, and therefore not eligible for charity care through the Dallas district, and to then find funding sources for them.

"I was in the same mode I had been in — trying to develop benefits. But these were health care benefits that could get hospital bills paid for these out-of-county patients, who represented between 5% and 10% of the patient population," she explains. "I was able to do that through some of the same programs I had been working with. My goal was to get the bills paid and find a place to refer the patients in their own county where they could receive future medical care."

As she developed the program, Daniel says, she educated hospital staff so they would know how to manage the needs of these patients, integrating the information into the financial registration practice of the hospital.

"I realized the key to making this work was hiring registration staff that would register only out-of-county patients," she adds.

Expertise leads to advancements

As program director, she supervised social workers and nurses, Daniel notes, and eventually also had registration staff reporting to her. "I recognized that out-of-county patients were being registered inaccurately across the system, and weren't being asked to meet their financial responsibility in advance in nonemergent cases."

After five years of directing the out-of-county program, which was under the umbrella of the hospital's patient services department, Daniel was promoted to director of patient services. At this time she took on oversight for social work, home care, interpreters, and drug and alcohol services.

Two years later, she says, the position of admissions and registration director became available, and the hospital's chief financial officer — someone who, interestingly, she had first worked with when he was the accountant at the Access Center for the Elderly, offered her that job.

"He asked me to serve, knowing I had networked with social work, nursing, and medical personnel across the system already," Daniel points out. "He knew I had the leadership and

people skills needed to run the department."

Daniel recently left that position and now is the associate vice president of a private company in the field of third-party eligibility where, again, her eligibility expertise is important.

Over the course of her career, she has served on more than 20 Health and Human Services advisory boards. At present, she is a member of the board of the Washington, DC-based National Association of Healthcare Access Management, serving as chairman of the government relations and public policy committee.

The third hallmark of Daniel's career, in addition to networking and the continuing focus on eligibility work, is her belief in the importance of education.

"Sometimes education will open doors, show people what you're able to achieve," she says. "When I was 26, I went back to school, realizing I would not get ahead with just a bachelor's degree. It nearly killed me, but I got a master's in counseling in two years."

That philosophy has influenced her own hiring decisions, adds Daniel, who says she has always sought to raise the level of expertise of those who worked under her. "I've hired people with master's degrees, even if the degree is in an unrelated field. It shows the person is able to complete a long project and manage it successfully."

(Editor's note: Patti Daniel can be reached at pdaniel1021@sbcglobal.net) ■

Dedicated ED issue sparks more debate

Urgent care centers addressed

The question of whether urgent care centers that are not associated with a hospital are covered under provisions of the Emergency Medical Treatment and Labor Act (EMTALA) is receiving renewed attention.

In a recent *EMTALA E-Bulletin*, **Stephen A. Frew**, JD, a longtime specialist in EMTALA compliance issues and a web site publisher (www.medlaw.com), said he had received reports that Southern California urgent care centers are getting conflicting information on whether the law's reference to "dedicated emergency department" applies to them.

Frew had a simple response to those who are being told that such urgent care centers are covered by EMTALA: "Wrong answer!"

Noting that he was quoting directly from material from a recent Centers for Medicare & Medicaid Services (CMS) EMTALA conference in Denver, Frew said a dedicated emergency department is defined as "any department or facility of the hospital, regardless of whether or not it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. "'It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department.
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.'"

The argument in Southern California, Frew says, has centered around whether urgent care centers meet condition 2 or 3. "CMS says that they probably do not meet No. 2 — which I think is incorrect," he says. "They obviously meet No. 3."

All that doesn't matter, though, Frew contends, because the entire EMTALA law applies only to hospitals and hospital-owned and operated facilities. "You don't even get to consider items 1, 2, or 3 until you apply the first set of conditions. Those conditions are that the urgent care center is a department or facility of a hospital.

"Freestanding urgent care [centers] that are not owned and operated as departments or facilities of the hospital are private physician offices and are not covered by EMTALA," he says.

Frew adds that even if state law were to wrap them into the same "EMTALA-like" rules as hospitals, CMS still would not be able to enforce EMTALA against these private urgent cares.

"While CMS conditions of participation allow it to enforce state laws," he continues, "they do not give [CMS] jurisdiction to enforce them against nonhospitals, because the conditions of participation apply to hospitals."

The tough question, he says, is whether CMS

would try to stretch its authority and the law to get at private urgent care centers. Frew says that is unlikely.

"[CMS has] enforced EMTALA against hospitals for all sorts of things that some people feel were stretching the bounds of reality — but those were hospitals and hospital departments," he points out. "Given the fact that they backed off of almost all of the other off-site and nonmedical services on campus for EMTALA application, it would be a bizarre stretch of imagination for them to cite a private urgent care center." ■

NEWS BRIEFS

NJ group suggests billing, collections guidelines

The New Jersey Hospital Association has unveiled billing and collections guidelines designed to help hospitals respond to the needs of low-income, uninsured patients.

The move follows various actions by hospitals across the nation and some state legislatures to bring clarity to policies and procedures regarding those who are struggling to pay their hospital bills. **(See *Hospital Access Management*, May 2004, cover story.)** Attention was focused on the subject as the result of a February 2004 statement from the Bush administration encouraging hospitals to give discounts to uninsured patients and financially needy Medicare beneficiaries.

The New Jersey guidelines were developed by a task force of hospital executives in response to the state's growing number of uninsured, which is now 1.2 million. Among other things, the guidelines say hospital financial aid policies should be consistent with the mission and values of the hospital and take into account each patient's ability to contribute to the cost of his or her care.

The guidelines also say hospitals should work with patients when necessary and appropriate to create a reasonable payment plan.

The American Hospital Association in Chicago has encouraged hospitals to review their billing and collections guidelines, and issued a set of recommended practices in December 2003. New Jersey is one of the first states to issue state-level guidelines. To read the guidelines, go to www.njha.com ▼

ED problems highlighted: Cost, capacity issues cited

An estimated 2.8 million adults who sought care in hospital emergency departments (ED) in 2001 reported delays or access problems, according to a study recently published in the *Annals of Emergency Medicine*.

That is about 7.7% of the estimated 36.6 million adults who sought care in a hospital ED that year.

Waiting time was the most frequently noted access problem, but concerns about health insurance coverage and the cost of emergency medical services were also commonly cited. Access problems were more likely to be reported by patients who were young, poor, and uninsured, and those in worse health were disproportionately at risk, the study found.

Study reveals capacity challenges

Meanwhile, a recent survey by the Chicago-based American Hospital Association highlighted hospitals' varying ED capacity challenges.

Inpatient occupancy rates captured at midnight fail to reflect volume fluctuations by day and time of day, the study found, illustrating the difficulty

of anticipating and responding to changes in demand. According to the study, those changes can be extreme.

The case studies done by the Lewin Group follow up on a 2002 national survey by Lewin that revealed that nearly 80% of urban hospital EDs are at or over capacity, with more than half reporting diversions.

The latest survey looked in depth at 28 hospitals in four communities — Louisville, KY; Portland, OR; Harrisburg, PA; and El Paso, TX — to see when and where capacity constraints occur within the hospital and how diversion situations develop across a community. The study found capacity constraints and ambulance diversions continue to be concerns in these communities, with more than half the hospitals in each community reporting their EDs at or over capacity.

Though all of the communities experienced some level of ambulance diversion, diversion hours varied by community, as did the factors driving the diversions and hospital capacity constraints. Even within a hospital, the specific capacity issue leading to diversion differed across the three days studies.

Summaries of both the 2004 and 2002 survey results can be found at www.aha.org ▼

Final stretch proves tough in HIPAA privacy effort

Health care providers are getting close to being in full compliance with the Health Insurance Portability and Accountability Act's (HIPAA) privacy requirements, which became effective in April 2003. However, getting to the finish line is proving difficult, according to a survey conducted by the American Health Information Management Association.

The survey of nearly 1,200 health care privacy professionals on their organizations' level of compliance with the HIPAA privacy standard was reported in a recent issue of *Modern Healthcare.*

About 68% of the 1,192 HIPAA-compliance professionals surveyed (more than half worked in hospitals), said their facilities were between 85% and 99% compliant with the rule, while 23% said their organization was fully compliant.

However, some 39% of respondents said accounting for the release of protected health information was an ongoing problem area, and 33% said obtaining protected health information from other providers was another compliance trouble spot.

In another development regarding the privacy standard, the American Hospital Association (AHA) recommended additional changes to eliminate problems with the rules that interfere with essential hospital operations.

AHA president **Dick Davidson** urged the Department of Health and Human Services (HHS) to adopt solutions to eliminate the paperwork and other burdens associated with accounting of disclosures and business associate requirements.

For example, the rule now imposes what Davidson says is an unnecessary paperwork burden on hospitals to account for numerous and frequent disclosures of information that they must make to public health authorities, regardless of whether any patient ever requests such an accounting of disclosures. The rule also requires business associate agreements between health care entities that are already covered by the rule.

AHA also encouraged HHS to share information obtained from efforts to monitor compliance to help hospitals understand best practices. ▼

Almost half of U.S. adults lack health literacy

Almost 90 million Americans, or half of the adult population, do not have the ability to understand and make informed decisions about their health. This situation may cause billions of dollars in avoidable health care costs and higher hospitalization rates and use of emergency services, according to a report recently released by the Institute of Medicine.

The report, which can be found at www.iom.edu, recommends that health care systems, educators, employers, and community organizations

COMING IN FUTURE MONTHS

- Innovative customer service strategies
- 'Access Career Path' reaches VP level
- Getting prepared for the HIPAA security deadline
- Strategies for staff training
- Cash collection success stories

develop programs to improve health literacy — the degree to which individuals obtain, process, and understand basic information and services needed to make appropriate health decisions.

For example, the report says patients need health literacy to discuss care with health professionals and to understand patient information sheets, consent forms, and advertising. ▼

State cutbacks affect health coverage for low-income families

Health care services for low-income families continue to face cutbacks as state budgets are adopted for fiscal year 2005, according to a new report by the Center on Budget and Policy Priorities. Georgia, Florida, California, Missouri, and New York are among the states that have adopted or are considering limiting eligibility for health insurance programs for low-income families in their fiscal year 2005 budgets. For example, the Georgia state legislature has just approved a budget that reduces Medicaid eligibility levels for almost 20,000 pregnant women and infants. And the Missouri legislature is considering a reduction that would heavily cut Medicaid, thus ending coverage for about 65,000 low-income people, including 41,000 low-income parents and 21,000 children.

Thirty-four have adopted cuts, which will result in 1.2 to 1.6 million low-income people to lose health insurance. Children and parents in families in which the parents work at low-wage jobs are expected to be the most harshly affected. For instance, Texas will end coverage under the Children's Health Insurance Program for nearly 160,000 children in working families, and Connecticut reduced Medicaid eligibility for parents with incomes from 100%-150% of poverty, with about 20,500 parents affected. Six states — Alabama, Colorado, Florida, Maryland, Montana, and Utah — have stopped enrolling eligible children in their State Children's Health Insurance Program. In addition, new or higher copayments for public health insurance services were imposed by 21 states for fiscal year 2004.

Research has shown that copayments are a significant deterrent to the use of essential medical care and prescription drugs among low-income populations, and that there are adverse health consequences when such treatment is foregone or delayed. The report can be found at www.cbpp.org/4-22-04sfp.htm ■