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

AUGUST 2004
VOL. 23, NO. 8 • (pages 85-96)

Team approach produces dramatic reduction in denials

Collaboration depends on 'atmosphere of trust'

As the newly hired patient financial services director at St. Helena Hospital in Deer Park, CA, **Kim Meredith** was ready to put her focus on reducing the institution's denial rate.

Looking at some of the reasons for those denials, Meredith says, she knew she would need help — from her colleagues in admitting to address demographic and authorization problems, from medical records to correct diagnosis and coding errors, and from case management to target denials related to concurrent review.

The challenge, she realized, lay in convincing those departments to join together to embrace the denial reduction quest without finger-pointing or airing dirty laundry.

Typically, Meredith knew, "directors don't want others involved in what I call 'their backyard,'" she says. "No department runs perfectly. Why do I want admitting [personnel], for example, looking at my backyard when I might have incorrect processes?"

Keeping that in mind, the CAMP team (the acronym was created from the first letter of each department's name) was born, Meredith adds, with the initial emphasis on developing interpersonal relationships and creating an atmosphere of trust.

"We had an informal meeting once a month to find out what was going on," she says. "We talked about things like, 'What's happening in your department? Two people are out sick. Cash collections are looking good.'"

Meredith describes this phase of the collaboration as "zero to six months — like the infant stage," and she emphasizes that it was crucial to the effort's ultimate success.

"Once we were comfortable that no one was trying to butt into another person's department, we started problem solving," she says.

To create a common goal, something that every employee of all the CAMP departments could work toward, Meredith notes, she came up with a bonus structure based on exceeding net patient revenue. She

then presented it to the CAMP team, and ultimately received the blessing of hospital administration.

The minimum bonus that each person receives if the hospital exceeds the net patient revenue goal is $25, and the amount increases according to how far above the goal collections go.

"Money motivates people," she says. "A lot of people say it doesn't. But I have to tell you, from this example, it does. We have been extremely successful."

The figures speak for themselves. Since November 2001, when CAMP started, hospital collections have increased dramatically, Meredith explains. "In 2002, we collected $14 million more than in 2001; in 2003, we collected $8.7 million more than in 2002; and for 2004, as of May, we collected $5 million more than during the same period last year."

For a 181-bed hospital with a combined annual operating budget of $2 million for the admitting and patient financial services departments, she adds, "that's a pretty significant amount."

The denial rate, meanwhile, is down to less than 1%, from a previous high of about 5%, she says, and accounts receivable (AR) days have been reduced from about 67 to 48.

"The whole concentrated focus of CAMP," notes admitting director **Peggy O'Neill,** "is assigning the denials to the appropriate CAMP party, which works until it resolves the root problem." The results speak for themselves, she adds, citing one recent month in which $800,000 in potential write-offs was reduced to $50,000 through the team's efforts. **(See Actual Denials vs. Potential Write-Offs chart for 2003, p. 87.)**

O'Neill and her staff have "played a significant role" in those statistics, Meredith reports. St. Helena has placed at the top of Adventist Health's 20 hospitals in over-the-counter (OTC) cash collections for the past two years and has been recognized for overall process improvement. **(See related article, p. 88.)**

"Because [admitting] was so successful with upfront collections," Meredith adds, "it has reduced the cost on the back end. We don't have to bill patients — with the additional expense of mailing statements — and our accounts receivable [AR] days are down because those self-pay dollars aren't sitting out there."

"There are no territorial walls that impede our working together," O'Neill says of the CAMP collaboration. "This group of departments maintains a highly developed communication network. We are all part of one constantly evolving improvement process."

The CAMP team, which includes directors and supervisors from each of the four departments and the hospital controller, meets on the last Wednesday of every month, Meredith says.

"What we've done is establish a common playing ground," she adds, "and to get to where we want to be, we [ask], 'What are the internal problems in CAMP?' and 'What are the external issues?'"

To increase efficiency and camaraderie, Meredith notes, the team developed a shared drive on the computer system that allows everyone in 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), $199. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

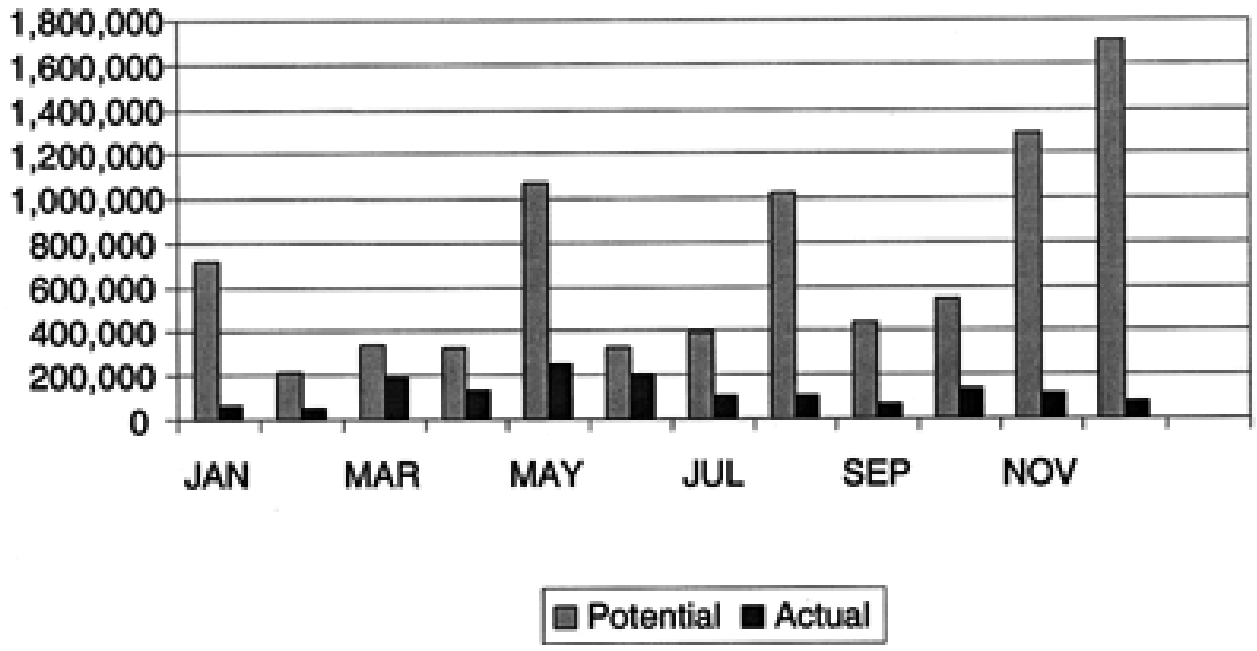
Editorial Questions

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**.

Actual Denials vs. Potential Write-Offs, 2003
(in Dollars)



Source: St. Helena Hospital, Deer Park, CA.

four departments immediate access to "the information we're tracking and logging, including denials, resource utilization group [RUG] rates, and daily cash."

The monitoring of "daily cash," meaning the amount of revenue coming in, shows the CAMP employees where they stand in terms of exceeding the net patient revenue goal, she adds. "We can see how much we collect every day, and how close we are to our goal."

Representatives from other departments occasionally attend the CAMP meetings, Meredith says. "We have invited other departments because it's important to find out, for example, why a department is having a problem with charge entry, and to ask, 'What can we do to help you get your charges correct, or to get the correct demographics?'"

The hospital is unable to bill Medicare for services provided at its transitional care unit (TCU), for example, until the unit provides patient financial services with what is called a "RUG analysis," she points out. "It's a complicated form that they complete and from that, they give us the RUG rate.

It takes 60 days to bill Medicare for that service. In the meantime, the patient goes to another facility and exhausts his or her skilled nursing benefits under Medicare, which results in the hospital not being paid at all, she explains. "We invited the TCU director in to talk about why they're having such difficulty giving this information to patient financial services."

Explaining the 'financial engine'

CAMP has taken the initiative in providing "financial engine information" to clinical staff, Meredith says. "A nurse has no idea how charges, CPT codes, or billing happens. We go out and do education for nurses so they'll understand how this works."

In the monthly CAMP meetings, the team looks at "items to target and areas to look at," she adds. "We talk about what to focus on next. What are the different areas we need to help improve their cash position; outline a game plan? Maybe it's the emergency department."

If that's the case, the director might be invited to sit in on a CAMP meeting, Meredith says. If there is a need for staff education, team members may go to the outside department in question.

"We conduct training classes for the departments that do charge entry," she notes. "We talk about how to know if you've made a mistake. If we see that physical therapy is struggling with putting in the correct date of service, we ask them if they want to be in their environment or come to us [to get help]."

Any or all of the CAMP team members may get involved in these endeavors, depending on the issue, Meredith says. "We all take an active role, but 70% of the education is provided by patient financial services and admitting. It's easier for us to identify issues with other departments because we can manipulate our computer system to see that information very easily and extrapolate variances to target areas of concern."

Time to celebrate

When the CAMP departments exceed the net patient revenue goal, she adds, "it's important that we celebrate as a group and extend an invitation to the outside departments we've worked with. When we resolved the issue with the TCU, we invited the director and whoever helped her resolve the problem."

In 2003, there were nine months of success, and so there were nine celebrations, Meredith says. As of June, CAMP already has had five successful months in 2004, and has celebrated each of those. The celebrations have run the gamut, from ice cream socials where old movies were shown to exotic lunches, she adds. "They've mostly centered around food."

"It's also very important to note that these celebrations cost the hospital very little financially," she points out. "There's a grill that we keep here, and I buy $50 worth of hot dogs and hamburgers, and we roll the grill down the hill from my office to the hospital."

One department might be responsible for bringing desserts, while another contributes salads or covered dishes, Meredith adds. "It might be a Hawaiian luau, or have a baseball theme. We just did "Around the World," with seven different continents represented. Staff walked through a kind of maze to different areas to pick up food."

The celebrations are important, she reiterates, because they reinforce the teamwork concept. "We work together, we celebrate together."

[Editor's note: Kim Meredith can be reached at (707) 963-6226 or meredikb@ah.org. Peggy O'Neill can be reached at (707) 967-3687 or oneillmm@shpo.ah.org] ■

OTC collections boosted with 'enthusiasm of sports'

Hospital leads 20-facility system in collections

When **Peggy O'Neill,** admitting director for St. Helena Hospital in Deer Park, CA, began tackling the improvements involved in a major restructuring of the admitting department, she looked first at the bottom line.

Very aware of the 18 new workstations, 18 new scanners, and assorted software that had been purchased — not to mention a new FTE (full-time equivalent) structure and additional staff — "the financial side of me" wanted to start paying those bills, O'Neill says.

"It's not that we didn't focus on other issues like denials and accuracy — those were moving along — but I wanted to show a return on investment by showing what we could do in over-the-counter [OTC] cash," she adds.

OTC goals met and exceeded

Going into 2002, the department's upfront collections were averaging less than $5,000 a month, O'Neill reports. She was in the midst of reinventing the hospital's admitting process, which was extremely decentralized, and some positions were not yet filled, she adds. "I didn't have a supervisor until July 2002."

O'Neill set — and met — monthly OTC goals of $20,000 for January/February 2002; $30,000 for April/March 2002; $40,000 for April/May 2002; and $50,000 for July/August 2002.

"After that, we took [the goal] up to $80,000 per month, which we had exceeded in July, and kept it there the rest of the year," she says. "We went up and down. Plotting out the goal is not an exact science when there is no history to build on."

Part of the process, O'Neill adds, was looking at the payer mix and patient volume in various areas to get a sense of the collection possibilities. And she gives her staff much of the credit for the initiative's success.

"I'm very blessed with a group of people who were committed to this," she says. "I have never been disappointed by them at all. You have to find the right person, and you have to use some tools that make it worth their while."

A couple of years ago, O'Neill notes, she

asked the question, "How can we get the enthusiasm of weekend sports and apply it to the work environment?"

Much of the answer, she discovered, was based on constant communication, beginning with creating charts on how much each person was collecting and looking at monthly goals and accomplishments.

"A history started building, and momentum started building," O'Neill says. "Two-and-a-half years later, it's so ingrained in this culture that no matter who comes and goes, on average, we exceed $80,000, and some months we've hit $138,000."

The figures for 2004 look even better, she notes. As of late June 2004, "we are 10% ahead against our [admitting collections] goal for the year. The first month we [collected] $155,000, and we've been averaging $98,000 a month for the first 5½ months."

For two years running, O'Neill says, St. Helena has led the 20 hospitals in the Adventist Health system in OTC cash collection.

The right skills and technology

What has helped the collection effort, O'Neill says, is the right mix of skills on the front end, combined with the proactiveness that has been the theme of the entire admitting initiative.

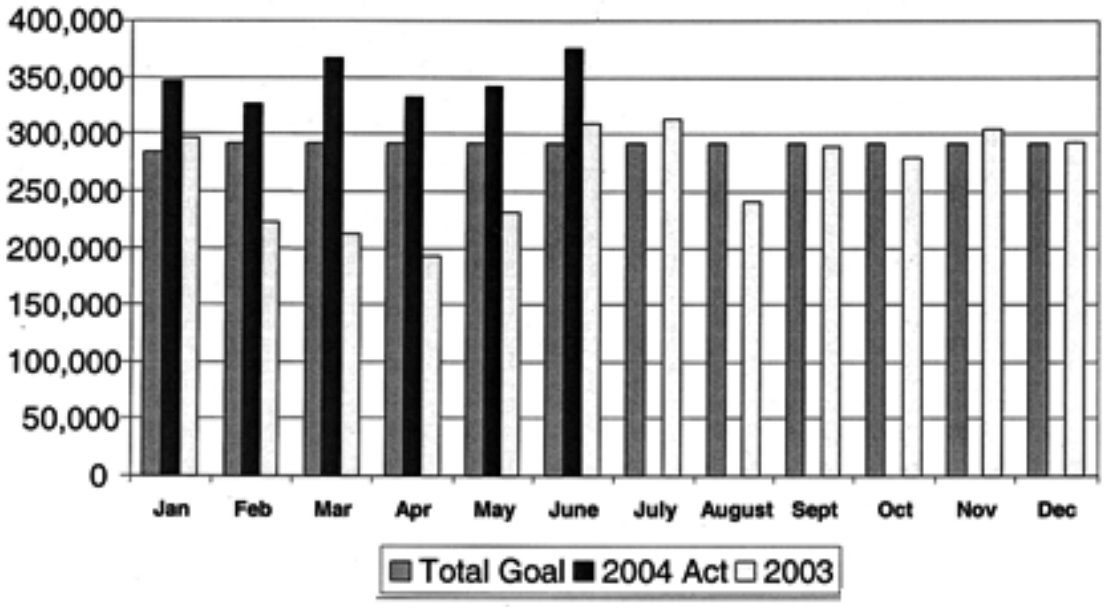
"We have two people — one in surgery and one in scheduled outpatients [diagnostics] — who do nothing but pre-registration of people who are coming in," she says. "That wasn't being done when I got here. I had to convince the team leaders in the diagnostic outpatient area [radiology, cardiology, etc.] to transfer from pen-and-paper scheduling to a homegrown on-line system so the admission staff would have access to the schedule."

The shell of the on-line scheduling system came from software developed by an information systems analyst at a nearby Adventist Hospital, O'Neill notes. "It has any number of applications, but the most useful one is [scheduling]. I learned how to build the system so it could be customized to include the information each department needed."

The potential for customization helped sell the idea to the diagnostics team leaders, O'Neill says. "I said, 'Tell me what criteria you need, and let's see if we can put this together.' We went back and forth a couple of times."

For the women's center, for example, there were places to indicate the location of the patient's most recent mammogram films and whether she had breast implants or hip replacements, she adds.

Combined Collection Goals and Actual Totals
(2004 Act vs. 2004 Plan, and 2003 Actual in Dollars)



Source: St. Helena Hospital, Deer Park, CA.

Although the need to schedule multiple visits at once has made use of the on-line scheduling system problematic for the physical therapy department, O'Neill notes, "I'm not giving up on it."

Eventually, every area except physical therapy changed over to the on-line scheduling process, she says. "That was the tool I needed to provide information upfront to the pre-registration staff so they could work one or two days out and then pass the patient's information on to the financial counselor, who can call the insurance company to confirm coverage."

The financial counselor looks up the patient's deductible or copay, figures out the coinsurance based on the appropriate contract or plan, and then telephones the patient at home to work with them to procure an upfront deposit, O'Neill explains. If copay is due at registration, she puts a note on the account alerting the registrar, she says. If the patient is unable to pay, the financial counselor works out a payment plan, or determines if the person is eligible for MediCal.

"We're not successful with all cases, but there is a dramatic difference from what we were getting before."

The conversation, O'Neill continues, goes something like this: "I see from the notes here that so-and-so spoke with you and that you have a $250 copay today. How would you like to pay for that?"

While some employees felt comfortable right away asking for the payments, she notes, prepared scripts have helped others ease into the practice.

Before the pre-registration process was instituted, she says, "the knowledge wasn't there," and with 110 patients a day, it was difficult to make any serious effort toward collection. Now, O'Neill adds, between 96% and 98% of scheduled accounts are pre-registered.

The pre-registration initiative also has helped reduce patient wait time, she notes. "The information is solid, the verification has been done. The patient just signs the Conditions of Admission and consent form, and we get a copy of the insurance card." If the card has been scanned during an earlier encounter, she adds, "we don't even have to do that."

While efforts were being made on the personnel side, there were also major changes taking place on the technological side, O'Neill points out. New Advance Beneficiary Notice software alerts staff up front about procedures that might not be covered by Medicare, helping reduce potential denials, she says. And as of a year ago, the hospital has on-line web access through the HDX system to eight or 10 commercial payers, as well as Medicare and MediCal, that tells staff what coverage the patient has and what the copay will be.

New scanning software allows employees to scan insurance cards and physician orders, O'Neill adds.

ACRP program boosts collections

St. Helena is one of the few hospitals in California that offers an inpatient stay for the treatment of chemical dependency, O'Neill says, and the Acute Chemical Rehabilitation Program (ACRP) has been a big contributor to its cash collection totals.

A $12,000 payment is due up front if the patient has no insurance coverage. But before the recent OTC effort began, there was no organized approach to collecting or measuring upfront cash, O'Neill explains. "When I started, they were collecting between $70,000 and $90,000 a month."

"Usually, those kinds of programs are a little more lax in getting payment up front, which is deadly with dealing with behavioral health," she points out. "Nine times out of 10, you write it off if you don't get it up front." If patients have a successful outcome with the program, but then later backslide, O'Neill adds, the attitude may become, "It's not working for me. I'm not going to pay."

Now, she says, the OTC collections goal for that program is $162,000, and recent monthly totals have been $209,000 and $212,000. The highest monthly total to date for the combined OTC collections of admitting, ACRP, and the Center for Health Transformations, which treats conditions such as eating disorders and nicotine addiction, is $385,000, O'Neill says, which was reached in June 2004. **(See Combined Collection Goals and Actual Totals for 2003, 2004 chart, p. 89.)**

Successful OTC collection, she notes, requires "a balancing act between looking at programs that are rich [and] can be mined for over the counter upfront cash, and focusing on the $12, $25, and $75 copays in the ED [emergency department]."

Although the ED's OTC collections total for a weekend might be $700, while that for the Center for Health Transformations is $30,000, they are equally important, O'Neill adds.

"If you are promoting teamwork, that $75 in the ED should be looked at in the same way as the larger amount," she says, "because, by and large, the same effort went into it. It's about each

one of the team members contributing, keeping everybody on the same team, and recognizing everybody for the result of that total team effort."

(Editor's note: In the next issue of Hospital Access Management, *look for more details on how O'Neill built a "best-practice" admitting department at St. Helena Hospital.)* ■

Lawsuits unwarranted, says hospital industry

Hospitals already taking action

About 18 not-for-profit hospitals in 15 states have been hit with class-action lawsuits filed in federal courts challenging their tax-exempt status as charity institutions. The suits state a breach of contract based on an explicit or implicit contract with the government to treat needy patients with compassion in exchange for significant tax breaks.

The suits claim that these hospitals bill uninsured patients premium amounts while they negotiate large discounts with insurers, HMOs, and several government programs such as Medicare and Medicaid. In addition, when the uninsured patients are unable to pay, some hospitals go so far as to place liens on their homes and assess interest, fines, and legal fees.

The recent class-action lawsuits drew reactions of surprise and anger from industry representatives.

"I don't think it's appropriate," says **Michael Taubin**, partner in the law firm Nixon Peabody LLP, 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. "I was surprised at these lawsuits in that the increasing focus on this issue over the past year [has] made every hospital cognizant of the issue and reactive to it," he adds.

Help for uninsured already under way

Not-for-profit hospitals are already taking action, and many have been giving discounts to uninsured patients and financially needy Medicare recipients for some time under the name of charity care and uncollectible bad debt. "[The not-for-profit hospitals] need to clean up their policies and make sure they are applying them consistently," Taubin says, "but I do not think it is something that warrants that kind of action."

"The great majority of not-for-profit accounting systems do comply with the [charity care] regulations," Taubin says. "Hospitals are reviewing their top internal policies with regard to billing and collections for the uninsured to make sure that they are following their rules for charity care for sliding-scale patients who have the ability to pay for certain services based upon their income. [These patients] get discounts."

Thin financial margins a problem

Beth Keith, CHAM, director of patient business services at Touro Infirmary in New Orleans, strongly agrees that most not-for-profit hospitals are doing all they can for the uninsured as well as the underinsured.

"I have never seen a not-for-profit hospital take advantage of an uninsured patient," says Keith, who has worked at four not-for-profit hospitals and observed many more when she worked as a consultant.

The current focus on the uninsured is expected to have a "really scary" impact on the not-for-profit hospital industry that is already operating under a thin financial margin, she notes, pointing out the many heavy expenses necessary for operation. For example, "It costs, conservatively, $2 million for equipment upkeep alone just to run radiology." Keith notes. Added to that are the high insurance premiums that hospitals must pay to provide necessary pharmaceuticals and up-to-date equipment.

To stay solvent, she says, hospitals must try to get the insured, uninsured, and underinsured to pay whatever they can. This must, however, be done with compassion, and Keith adds that at Touro, "Basically, anyone who indicates a problem with paying their bill is offered the opportunity to apply for financial assistance."

These lawsuits are unlikely to produce significant changes, says Taubin. "I think the fallout has already occurred. I don't think these lawsuits are going to make any drastic changes in what hospitals are doing with regard to the uninsured," he adds. "Their antennae [have been] up for the last year. The [federal] government has been looking at this. The state associations have been looking at this. The state governments have been looking at this. I don't think these lawsuits are going to have any major change. I think hospitals are attuned to this issue right now." ■

Customer service exercises add spice to staff meetings

Bored faces disappear and attendance goes up

When the patient access department at the University of Pennsylvania Medical Center-Presbyterian in Philadelphia has its monthly staff meeting these days, there's an added attraction.

After the insurance updates, schedule changes, and other pertinent matters are handled, attendees are asked to participate in an interactive customer service initiative, says **Raina Harrell**, business administrator for patient access.

Taking an exercise she used in a previous access position, Harrell explains, she has challenged members of Presbyterian's nine-person patient access management team to take turns coming up with an activity to cap off the monthly sessions.

"It actually helps get people involved in the staff meetings, which some consider to be boring," Harrell says. "There is a game or activity, and [employees] may get picked or volunteer, or might get a prize, for being there."

"[Staff reaction] has been extremely positive," she adds. "When the activity comes, there are smiles and laughter, and we might get a question or two after that, as people become more relaxed."

Activity highlights personal strengths

Harrell started off the monthly exercises in April, with an activity that highlighted the special strength or personality trait that each person contributes to the patient access team.

"On colorful strips of paper, people wrote their name on one side, and on the other, the quality they bring to the team," she explains. As each person completed a strip, she adds, it was made into a loop and then, with a stapler, connected with the next person's "link" to make a chain.

"We had people who were customer-focused, friendly, detail-oriented," among other traits, Harrell says. "We talked about how each person added to the team. We took it so far as to say that, for example, on a not so good day, [the department trainer] didn't feel like teaching, so her link fell apart."

The exercise continued with co-workers helping her get through the tough time by repairing her link, she notes. "We all have good days and bad days, and we're expected to keep up whatever the day brings. So we need to help 'mend each other' to keep that link together."

That was a good beginning activity, Harrell points out, because it "got everyone involved the first time. Everyone had to speak."

As a reminder of the teamwork message, the chain that was created was circulated among the different patient access areas, with each keeping it for a few days or a week, she says.

In May, the department's manager of medical records used the food group pyramid as a symbol for the healthy whole that is created by the contribution that each area of patient access makes to the department, Harrell says. **(See Patient Access Department chart, p. 93.)**

"Admissions, where we register and assign beds, was like the meat group," she adds. "Central registration was like the dairy group. Without it, we wouldn't be able to register outpatients or direct patients to services."

"Sometimes one area feels like it is more important than another, but [the exercise] emphasized that all are important to the whole," Harrell says.

Exercise promotes teamwork

Employees got to try out some dance steps for the June activity, which was directed by **Shelly Potts**, the manager of quality assurance and training.

To represent the nuances of teamwork and training, Potts put together a series of dance steps for staff members to learn, she explains. In the scenario that was played out, she called someone to the front of the room to take the role of a newly hired employee.

In the same way that new employees are given manuals that explain their jobs, Potts says, she handed the person a written description of the dance steps. "Staff would also be given hands-on training, so we turned on the music and I showed her how to do the steps, and then said, 'Let me see you do it.' She was confused at first, but we did it over and over again until she got it."

Other parts of the exercise brought others to the front to learn from the first person, illustrating how the mentoring process works, and reminding those watching what it is like to be a new employee faced with absorbing a great deal of information, she notes.

To demonstrate the ongoing insurance updates

(Continued on page 94)

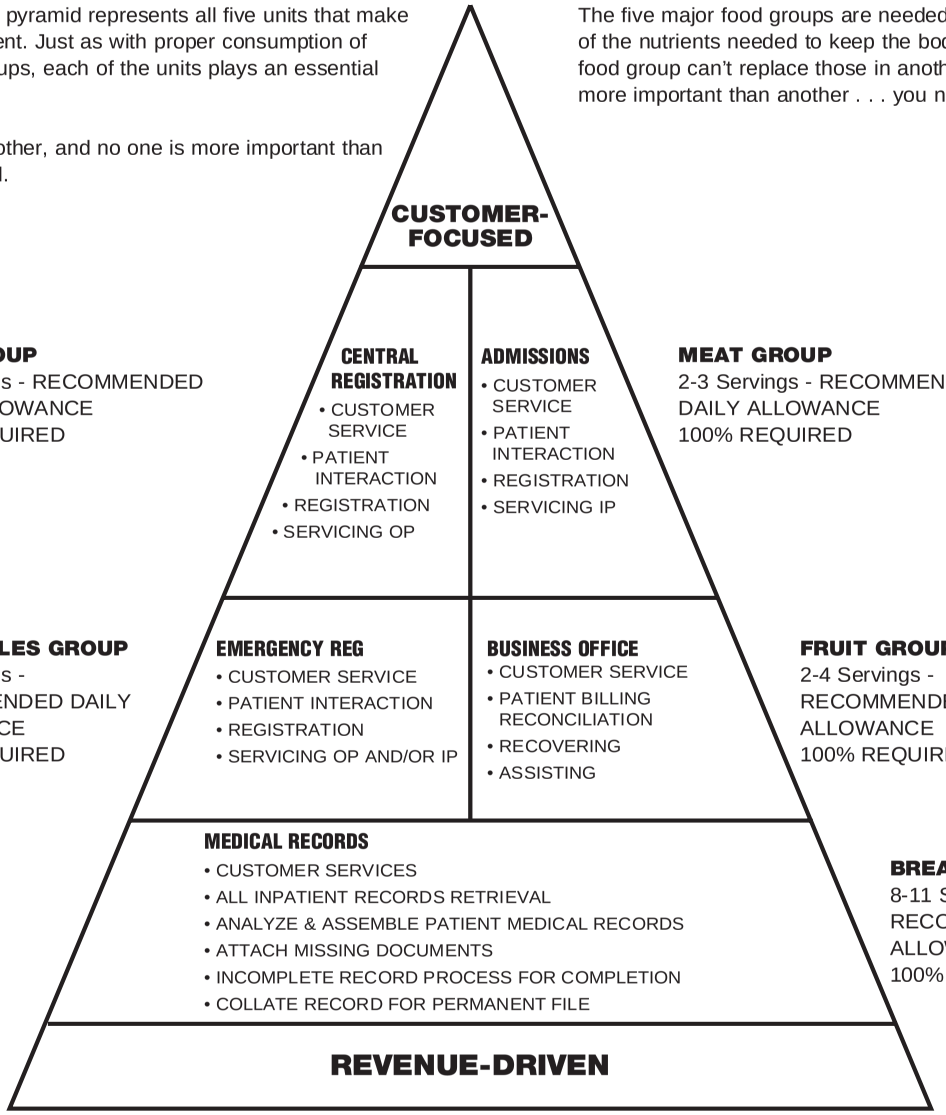
Healthy Patient Access Department

All parts needed for a strong unit!

The patient access department pyramid represents all five units that make up the patient access department. Just as with proper consumption of each of the five major food groups, each of the units plays an essential part for the whole.

No department can replace another, and no one is more important than the other . . . you need them all.

The five major food groups are needed to provide some, but not all, of the nutrients needed to keep the body healthy, nutrients from one food group can't replace those in another. No one food group is more important than another . . . you need them all.



MILK GROUP
2-3 Servings - RECOMMENDED DAILY ALLOWANCE
100% REQUIRED

MEAT GROUP
2-3 Servings - RECOMMENDED DAILY ALLOWANCE
100% REQUIRED

VEGETABLES GROUP
3-5 Servings - RECOMMENDED DAILY ALLOWANCE
100% REQUIRED

FRUIT GROUP
2-4 Servings - RECOMMENDED DAILY ALLOWANCE
100% REQUIRED

BREAD GROUP
8-11 Servings - RECOMMENDED DAILY ALLOWANCE
100% REQUIRED

Source: University of Pennsylvania Medical Center-Presbyterian, Philadelphia.

and other new material that is presented long after her training class is over, Potts says, she introduced a double clap to the dance routine. By that time, there were several people involved, all looking at each other to make sure they were doing it right, she adds.

The point was made, Harrell notes, that it's natural for someone to make mistakes in the early stages of training, and that with practice and reinforcement, the person eventually retains the information.

"By the end of the exercise, [the dancers] were in sync, dancing together and having a great time," she says. "There was someone from each area of access on the dance floor and everyone was smiling. There are usually such bored faces at the staff meetings."

Although the exercises might appear to be more about team building than customer service, Potts explains that the latter term fits because of the philosophy that defines the institution's access services department.

"Our theme is "Customer-Focused, Revenue-Driven," she adds, "and our customers are not just patients who come to the department. We are all each other's customers. The idea is, 'Treat others as you want to be treated.'"

Creating a theme

With the monthly exercises, Harrell continues, "what we're trying to do is build a theme of teamwork, showing little by little how each person and each department contributes to the team. We're trying to increase attendance at the staff meetings as well."

While typically about half the staff, if that many, attend the monthly meetings, she notes, there was a dramatic increase after word of the new format got out. At the next session, about 77% of the 80 people who might have attended were present, Harrell adds, and the number was up to 85% the next time.

"Attendance is getting higher and higher because people are talking about our staff meetings," she says. It doesn't hurt that the manager who is conducting the exercise that month also is providing refreshments, Harrell adds.

The more employees who attend the meeting, she points out, the less redo is necessary on staff inservices and other new information that is disseminated.

"The more fun you can make any part of work, the better off you're going to be," she says. "The more you can get them to smile, the more the staff appreciates it."

Another positive, adds Potts, is the interactive nature of the exercises. "It's not just [managers] getting up there talking. Employees appreciate it more when they can [contribute] something."

[Editor's note: Raina Harrell can be reached at (215) 662-9295 or by e-mail at raina.harrell@uphs.upenn.edu, and Shelly Potts can be reached at (215) 662-9298 or lachell.potts@uphs.upenn.edu] ■

ED volunteers help with patient communication

Program benefits students, patients, and hospital

The third stage of an ambitious campaign aimed at streamlining emergency department (ED) operations gets under way this month as Baptist Memorial Health Care in Memphis, TN, begins recruiting members for a new ED volunteer corps.

What's unusual about this hospital volunteer initiative — named "Experience Critical" — is that it is targeted to young people who may be considering jobs in the health care field. Organizers will look to college and university campuses to fill the ranks.

For several months, the hospital has been "experimenting with four volunteers between the ages of 18 and 21," says **Chuck McGlasson**, RN, MSA, assistant director of emergency services and pediatrics for Baptist Memorial Hospital-Memphis. "We're using them to help in the ED and trying to figure out what we want them to do."

The first phase of the campaign was launched in November 2003. It focused on heightening public awareness of the national problem of ED overcrowding, and made use of public service announcements and billboards. The second phase has involved hospital-based tactics, including communicating with and educating patients inside the doors of the facility and creating a special magazine about the ED.

It's clear that the duties of the ED volunteer corps, McGlasson says, will center on enhancing patient communication, which numerous surveys and studies have shown is the key to keeping patients satisfied, McGlasson says.

The mindset of most ED patients is, "If I've been registered, then I should be seen right away," notes **Beverly Jordan**, RN, vice president

of nursing for the Baptist system. "That's where the volunteers can come in. They can keep family members and patients aware of what's going on."

The average ED patient doesn't understand the triage system, McGlasson adds, and volunteers can help explain why "first come, first served" isn't the operative slogan.

Communication key to success

While Baptist Memorial has done much to streamline its admissions and registration process, she adds, a good experience in that area can be negated to a great extent if communication with the patient is not handled well.

"It's intriguing that all of our research [phone surveys and case studies] has shown that if a person has a less than positive experience in the ED, it's usually communication-related issues and not quality of care," adds **Courtney Liebenrood**, corporate senior public relations manager. "When [patients] have opportunities for improvement to suggest, it's all about keeping them informed: 'Where is my loved one? What's going on with them?' That's why the volunteer corps is so important."

In addition to addressing this need, McGlasson says, duties of the ED volunteers are likely to include such things as "running labs," stocking linens, providing blankets and pillows to those in the waiting room, and assisting with patient transport by carrying the person's belongings while an ED employee pushes the wheelchair.

"In a hospital, we know that the ED is the front door, where most of the patients come through, where there are high volumes," Jordan notes. "If you ask health care executives what keeps them awake at night, other than reimbursement, it's staffing and capacity. This [ED volunteer corps] helps both those things."

"With the health care work force shortages we're dealing with across the country, in the ED specifically," she adds, "if we have satisfied employees and patients, and if we help flow patients through the building, we've done our job."

Many people in the target volunteers' age group are naturally drawn to high-tech, high-intensity careers, Jordan points out, which makes the new program "mutually beneficial" for both the hospital and the volunteers.

Research has suggested that members of this generation are "pragmatic people who are planning early on for the future," Liebenrood says, and that "fun, nontraditional" means will be the best way to reach them. A poster being used to promote the volunteer program features the stark outline of a human head and in large type, the words "Experience Blunt Force Head Trauma."

In smaller type below, the message continues with "And cardiac arrest. And compound fractures." It goes on to call participation in Experience Critical a "career-building experience."

"We're using 'guerrilla tactics" like partnering with the university during freshman move-in week, sidewalk drawings, and building signage to creep into their consciousness," she adds. "We'll have stickers inserted in newspapers on the college campus, and giveaways like bottles of water that say, 'Experiencecritical.com.'"

Those who sign up to help will be offered flexible hours, McGlasson says, with the understanding that "traditional shifts can be thrown out the window."

"We'll be open to all shifts, but when we start recruiting, we'll look at the busiest time of day, which is 5 p.m. to 1 a.m.," he says.

"It's serendipitous," Jordan adds, "that the highest yield times [for the ED] work with college schedules. Weekends are the busiest times."

Allowing a couple of months for recruitment efforts to pay off, the volunteer corps should be in place in plenty of time for flu season, which can hit hardest, McGlasson says, any time from November to January.

Training will be extensive, Liebenrood says, with the ED corps receiving instruction from the hospital's regular volunteer managers, as well as "a little more specialized training" from the corporate communications department.

It is likely there will be one designated training day a week, McGlasson says, and it will be year-round and flexible.

[Editor's note: More information on Baptist Memorial's ED campaign and the volunteer corps is available

COMING IN FUTURE MONTHS

- 'Best Practice in Admitting' success story
- 'Access Career Path' reaches VP level
- Leadership Ladder boosts staff morale
- Financial counseling initiative pays off
- Strategies for staff training

at the health system's web site, www.bmhcc.org/

Courtney Liebenrood can be reached at (901) 227-3509.] ■

82 million Americans uninsured in 2002-2003

Nearly 82 million Americans younger than 65 went without health insurance for all or part of 2002 and 2003, according to a report released recently by Families USA.

About half of them were uninsured for nine months or more, and two-thirds for six months or more, the study found.

Most of the uninsured (78.8%) were employed or in working families, including one-quarter of Americans in households earning three to four times the federal poverty level ($55,980-$74,640 for a family of four). Hispanics and African-Americans were more likely to be uninsured and to remain uninsured for longer stretches.

Democratic governors speaking at a press briefing on the study expressed concern that the number of uninsured will increase even further as a result of the enhanced Medicaid matching percentages that expired June 30.

The report, based on an analysis of Census Bureau data conducted by the Lewin Group, is available at www.familiesusa.org

Estimates from the Centers for Disease Control and Prevention (CDC), meanwhile, put the figure for Americans who were uninsured during at least part of 2003 at 53 million.

The CDC's latest National Health Interview Study indicated that figure represented 23.8% of working-age adults and 13.7% of children younger than 18. About 15.2% were uninsured at the time of the survey, while 10% had been uninsured for more than a year, including 2.5 million more working adults than in 2002.

About one in 10 children was uninsured for at least part of the past year and 5.3% for more than a year, according to the survey.

For more on the CDC survey, go to www.cdc.gov/nchs/ ■

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

Many health care organizations still remain a long way from security compliance

URAC identifies four barriers to meeting security demands

Even though less than a year remains before the HIPAA security rule takes effect April 21, 2005, many health care organizations are a long way from compliance, according to an assessment by Washington, DC-based URAC, the only organization offering a security accreditation program based directly on the HIPAA security rule.

Written to minimize potential disruptions and security breaches to personal or protected health information (PHI), the HIPAA security rule affects:

1. how health care organizations interact with information systems that contain PHI;
2. methods by which organizations communicate with consumers, providers, and other third parties;
3. ways that health care organizations educate patients and obtain information about them;
4. the manner in which PHI is collected, used, and shared both internally and externally.

URAC officials say their accreditation review experience has identified four barriers that are hampering the ability of health care organizations to satisfactorily meet security rule demands:

1. Incomplete or inappropriately scoped risk analysis efforts. Risk analysis — formal identification of an organization's risk tolerance, outstanding risk liabilities or residual risk, and prioritization of subsequent risk reduction activities — is the fundamental building block of any security management program. The government will look to an organization's risk analysis as a primary piece of evidence when investigating security complaints and determining an organization's rationale for reasonable and appropriate controls. URAC says risk analysis as required by the security rule is a much more demanding evaluation of an organization's security posture than that from a typical vulnerability assessment.

2. Inconsistent and poorly executed risk management strategies. According to URAC, risk analysis and risk management are linked to ensure a sound security compliance strategy. Security risk management deals with allocating resources to gain the highest level of risk reduction possible within the bounds of an organization's risk tolerance. URAC says organizations must be careful not to rely too much on technologists to make risk management assumptions without clear guidance and support from the business operations perspective. All the organizations it surveyed were found to have serious issues with policy and procedure documentation, management, and implementation.

3. Limited or faulty information system activity review. According to URAC, the purpose of information system activity review is to provide an accurate history of system activity in the event of a security breach, and allows health care organizations to track system usage; reconstruct, review, and examine events; and detect and verify unauthorized users and processes.

4. Ineffective security incident reporting and response. According to URAC, much of the confusion surrounding the security incident response and reporting requirement centers on the question of what constitutes a security incident and what constitutes a sufficient level of reporting. The rule defines a security incident as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system." This element is closely linked with the other three, URAC says, because the ability to identify security incidents is heavily

dependent upon information system activity review, practicable mitigation requires an organization to have established risk tolerances as part of its security management process, and harmful effects must be linked to an organization's knowledge of its threats, vulnerabilities, and impacts.

Improve compliance preparations

Based on its consulting experience. URAC has recommendations to improve preparations for security rule compliance, including:

1. Health care organizations must focus on implementation of a sound security risk management process that includes a comprehensive, meaningful, and realistic risk analysis, risk management program, information systems activity review function, and security incident reporting and response process.

2. HIPAA implementation efforts should be managed in the broader context of overall business risk.

3. Health care organizations should begin preparations now because most security risk management programs can take up to a year to implement.

According to URAC, HIPAA compliance should not be seen as a costly regulatory burden, but rather as a way to appropriately manage ongoing security risks in a way that reduces overall business risk, reduces costs, and improves quality.

(Editor's note: The report can be downloaded from www.urac.org.) ■

OCR reports more than 5,000 complaints

Largest number filed against private practices

As of April 2004, the Department of Health and Human Services' Office of Civil Rights (OCR) had received more than 5,000 complaints from individuals about alleged HIPAA privacy violations. New Haven, CT-based Wiggin & Dana attorney **Jennifer Wilcox** says the largest number of privacy complaints was lodged against private practices, followed by hospitals, pharmacies, and health plans.

By the end of June, OCR had closed 48% of the complaints, including many that were settled easily on jurisdictional grounds — such as complaints involving problems before the compliance date, complaints against noncovered entities, and complaints filed more than 180 days after an incident. Wilcox says the complaints that OCR decided warranted further investigation fall into three broad categories: lack of adequate safeguards such as leaving charts in public areas or computer screens exposed to patients, etc.; improper accessing of protected health information, such as employees accessing protected information for nontreatment related reasons; and impermissible disclosure of protected information to third parties not involved in treatment.

According to Wilcox, OCR has received a large number of complaints about failure to disclose protected health information to family members. Although such a failure is not a HIPAA violation, OCR says it has provided technical assistance to providers who are the subject of such complaints so they realize that HIPAA permits such disclosure in many instances.

"Questions of disclosure to family members have received a lot of media attention since the HIPAA privacy act compliance date," she says, "and many providers who initially adopted very strict policies may be relaxing their approach due to the backlash. While providers may wish to be flexible in adapting their policies based on customer and patient feedback, they still need to remember that improper disclosures to family members can have serious implications."

To date, OCR has not sought civil monetary penalties or other official sanctions for any cases it has investigated. Wilcox says agency officials have indicated that providers have been cooperative with investigators, readily strengthening their policies or implementing training efforts in response to complaints. According to the OCR director, she reports, 50 complaints have been referred to the Department of Justice, the agency charged with investigating and enforcing criminal violations of HIPAA rules. OCR staff also indicated there are no plans to institute audits, compliance reviews, or other efforts to affirmatively look for violators.

Few court cases have yet addressed the HIPAA privacy rule, Wilcox says, although some courts have considered the privacy rule's pre-emption provisions in connection with several discovery requests and subpoenas. Analyses and interpretations of the courts that have looked at the provisions suggest that HIPAA pre-emption will be a difficult issue for courts to deal with in coming years, as seen in these decisions:

• A federal court in Louisiana ruled that HIPAA was more protective of patient privacy than state law, even though state law allowed patient records to be disclosed only with patient consent or based on a court order entered after a hearing.

• A federal court in Maryland concluded that HIPAA pre-empted a Maryland law that requires health care providers to disclose to defense legal counsel medical records relating to a patient's health, health care, or treatment that forms the basis of a civil action instituted by a patient, without the patient's authorization.

• A New Jersey state court said HIPAA did not pre-empt a practice authorized by state Supreme Court precedent in which defendants in all personal injury cases are permitted to conduct informal interviews with plaintiffs' treating physicians as long as specific patient authorization requirements are met. The court determined that the interviews did not conflict with the general principles of HIPAA and, as HIPAA does not expressly address informal discovery, New Jersey law should govern the practice. But it required that the authorization forms used be revised to meet HIPAA requirements.

• The question of HIPAA pre-emption also has come up in two courts that were addressing the constitutionality of the Partial-Birth Abortion Act of 2003. During discovery in those cases, U.S. Attorney General John Ashcroft issued subpoenas to several hospitals in New York and Illinois seeking medical records of women on whom certain abortion procedures had been performed. The court issued a protective order requiring elimination of certain identifiable information. In both cases, physicians argued that more stringent state laws precluded the disclosure. In the New York case, the court decided that the New York law did not apply to federal cases, while the Illinois court said that Illinois law applied because it was more stringent. The Seventh Circuit has affirmed the decision in the Illinois case, while the Second Circuit has stayed the New York court's order pending its decision. The government has withdrawn its subpoena for the New York hospital records, and Wilcox says it is thus unlikely the appeals court will rule on the legal questions.

Compliance deadlines

Extended deadlines for some compliance tasks have arrived, and covered entities should be sure they are up to date. Wilcox says covered entities were required to execute business associate agreements with vendors by April 14, 2004, and providers should be reviewing their contract process to be sure all existing vendor agreements are reviewed and business associate language added where appropriate.

Also, small health plans (spending less than $5 million on premiums or health care costs) had an additional year to comply with the privacy rule. Many of the smaller plans are fully insured and have significantly fewer compliance obligations. Wilcox advises organizations that sponsor benefit programs for their employees to review the nature of the benefits and be sure they are aware of what their compliance obligations are. Common programs such as flexible spending accounts that reimburse medical expenses or employee assistance programs may be considered HIPAA-covered entities, she says, and even smaller self-insured plans require compliance steps.

The HIPAA security rule compliance date of April 21, 2005, is the next major hurdle. Wilcox says HIPAA security implementation needs to be structured and documented according to the security rule's standards and implementation specifications. Although specific information technology solutions will help in achieving many of the security standards, she says, there also are organizational, systemic, and documentation issues that must be addressed. ■

Working Group concerned about claims rejections

Slow-Pay modification is at issue

The HIPAA Implementation Working Group, a coalition formed to help providers and vendors better understand the process by which the HIPAA electronic standards are developed and modified and to increase provider and vendor representation in that process, has contacted Centers for Medicare & Medicaid Services (CMS) administrator **Mark McClellan** to express concern over a CMS instruction to fiscal intermediaries to reject claims lacking certain data elements not needed by Medicare for claims adjudication.

The Working Group letter, signed by the American Hospital Association, American Medical Association, Association for Electronic Healthcare Transactions, Laboratory Corp. of America Holdings, and WebMD, urged that

CMS go no further in enforcing data content specifications and to focus instead on implementation of other transactions that will reduce administrative costs and benefit all participants in the health system.

The groups noted that because of the complexity and cost of the changeover to meet new administrative simplification standards, few trading partners were prepared to exchange HIPAA standard transactions on the Oct. 16, 2003, deadline, and CMS has permitted use of contingency plans during the transition phase as payers, clearinghouses, and providers continue to work out the thousands of details upon which successful transactions depend.

In its role as a payer, CMS also adopted a contingency plan for Medicare to ensure continuation of health care payments and provision of health care services while the transition effort is under way. The CMS contingency plan includes continued processing of health care claims submitted in the old "legacy" format while providers and payers resolve problems experienced exchanging transactions in the new HIPAA format.

Slow-Pay

The Working Group says health care providers and Medicare carriers and fiscal intermediaries have effectively used the contingency plan period to progressively migrate to the HIPAA format with limited disruption in health care payments or services, but contends that migration now is in jeopardy because of CMS' Slow-Pay modification that the Working Group says is contrary to the HIPAA objective of reducing administrative costs and increasing efficiencies.

Under Slow-Pay, fiscal intermediaries were told to reject institutional health care claims missing specified data elements not needed by Medicare to adjudicate the claims. The Working Group maintains the change in policy increases the data-collection burdens of and financial risks to providers.

"CMS explained its action to enforce data content specifications by stating that private payers require Medicare to include this data when submitting claims through coordination of benefits transactions," the Working Group wrote. "We suggest that it is counterproductive to accommodate the demands of what we believe are a very small minority of payers when those demands will provide little or no benefit for those payers, impose added burdens on all providers, and bring no return on the providers' investment of time and energy.

"We request that, going forward, CMS adhere to the principles of reducing administrative costs and increasing efficiency as outlined in the statute when implementing HIPAA. It is inconsistent with these principles to enforce extended HIPAA data content specifications prior to achieving systemwide format compliance for claims and implementation of other covered transactions that will bring immediate and systemwide cost savings." ■

Vendors agree on HIPAA interpretation 43% of time

The HIPAA Conformance Certification Organization (HCCO) says its Common Compliance Assessment Process determined that, on average, the nation's leading HIPAA translation and validation vendors agree in their interpretation of compliance 43% of the time, up from an average of 35% on all transactions in 2003.

The assessment is an advanced testing process that performs detailed analysis of HIPAA compliance edits across all vendors simultaneously. Testing takes place in a neutral environment to uncover compliance differences among participants and work to align edits. Participants in the 2003 and first quarter 2004 testing represent some 80% of the translators and validators installed in U.S. health plans, HCCO says.

"We have come a very long way, but there is still much work to be done in the process of aligning compliance edits in HIPAA translation and validation software," says HCCO chairman **Mark Lott**. "Many of the differences can be traced to differences of opinion within the language of the implementation guides, but with the help of X12, the authority for interpretation, we have made great strides in moving this key initiative forward. A very important result of the CCAP testing effort is that while differences of interpretation are present in the beginning of the testing process, all vendors have the same interpretation upon completion of the program. To date, CCAP has tested more than 1,100 transactions representing close to 100,000 various compliance edits, and through this effort the majority of the industry has the same understanding of compliance." ■