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Baycare gets a grip on payment denials

Payers, physicians brought in line

Some aggressive strategies for avoiding and, if necessary, challenging third-party payment denials are turning around a problematic situation at Baycare Health System in Clearwater, FL.

Baycare now requires physicians to have authorizations for most outpatient procedures by 10 a.m. the day before the scheduled service, says **Martine Saber**, CHAM, regional director of admitting for the 10-hospital system. "If they don't, we ask for the procedure to be rescheduled."

Emergent cases are excepted, of course, and Saber says the cooperation of the health system's clinical departments has been crucial in that regard. "If we notice that a [supposedly emergent] case was scheduled two weeks ago, I'm not in a position to argue, but the clinician is."

Baycare is looking into going one step further, she says, and is refusing to schedule nonemergent outpatient procedures without an authorization. "We did a survey within our county and found that no other hospital has such a policy. But when we said we were considering doing it, they said, 'Great. If you do, we will.'" The problem, Saber adds, is that "no one wants to be the first one."

A concerted effort at physician education already has had dramatic results in increasing the number of procedures scheduled with authorizations, she says. Although the improvement is anecdotal at present, the health system's comprehensive new denials database **(see *Hospital Access Management*, May 2000, p. 57)** soon will provide hard evidence, Saber notes.

Outpatient surgeries and cardiac catheterizations rarely have to be rescheduled, she says, because the

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In Brief

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physicians have a strong incentive to get the authorization: Unlike for other outpatient procedures, if they don't get the approval, they don't get paid.

Even with the surgeries and cardiac catheterizations, her department would like to be informed of the authorization in a more timely manner, Saber says. "What happens is the physicians book the procedure before authorization, which they're not supposed to do, and we usually have to make one or two phone calls." That's down, however, from the 10 or so phone calls it took previously, she points out.

"We now call [the physician's office] at preregistration and ask for the authorization, and again one day before [the service date]," she says. "If we don't get it then, we tell them we'll reschedule."

Her department also is increasing its use of faxes to obtain authorizations from physicians, Saber notes, and has an on-line connection with Blue Cross Blue Shield that allows registrars direct access to authorizations that already have been obtained by physicians. Plans are under way to set up similar connections with other insurers, she adds.

For the most part, physicians have been cooperative with the efforts to reduce denials, Saber says, and much progress has been made. The ongoing frustration is that "the insurance companies are playing so many games with us. We're spending so much money fighting to get paid."

As part of compiling a "managed care cookbook," Saber says, her department requested from insurers a comprehensive list of services that require authorization. "Very few wanted to do that," she adds. "They said, 'We don't have a list. You just have to call.' So we're making our own list, finding out through getting denied."

Through information gleaned from the denials database, Saber says, her department is discovering past mistakes and finding ways to correct them. For example, there were 10 designated codes for tagging a denial, with "0" indicating a patient didn't provide proper information and therefore was not eligible for the service; "1" meaning the authorization was never obtained; "2" meaning the insurance company was notified too late, and so on, she explains. "We really didn't do a good job of tagging denials correctly, and it is important to know those reasons. Some were tagged as denials, and they were not really denied."

As a result, Baycare is now creating a tool that includes an explanation of the codes with

examples so that whoever is tagging a denial will do it correctly, Saber explains. "If it's tagged because of medical necessity, we [in access] don't work it. Utilization review will work it. But if it's tagged because there is no authorization, we will work it." Before, she adds, personnel wasted time determining who should handle a particular case.

Another benefit of the denials database is that it compiles information from all 10 Baycare hospitals, making for more compelling challenges to the third-party payers, Saber says. "We're working right now with two of the biggest insurance companies, CIGNA and Aetna. We now can combine all of the information, drop it in their laps, and say, 'You denied us this. You need to pay us.'" The argument is more convincing when it involves more than $1 million dollars, as opposed to a couple of hundred thousand, she adds.

Bring on the lawyers

Although Baycare's managed care contracts specify that it will be notified within so many days if a new procedure goes on the "must be authorized" list, insurance companies do not always comply, Saber points out. When they do send notice of changes, they often send them to the wrong person, she says. "They do it on purpose. What we're doing now is putting it into the contract that they must notify us of changes by registered letter." The health system is hiring legal counsel to enforce the requirement, she notes.

"We're getting better at the contracting level," adds **Donna Miller**, MHS, special projects coordinator for Baycare's continuum department. "The people who write our contracts are getting very savvy in the ways in which managed care companies find opportunities to deny us. We're trying to work out contractually that if we're providing care at the direction of the physician, who is their agent, it is not our job to police their physician. We are only the provider of the care that physician orders. We can't admit or discharge without an order from a physician.

Correctly designating the patient's level of care continues to be a challenge that often leaves the health system caught between the demands of managed care companies and the requirements of the Health Care Financing Administration (HCFA), says Miller.

The issue revolves around whether a person is deemed an inpatient or an observation patient, Miller notes, with the latter theoretically requiring a lesser level of care for which hospitals receive a lesser reimbursement.

"The real problem has been that a patient may come in with chest pain or abdominal pain and be admitted as an inpatient through the emergency department," she adds. "We do some diagnostic tests and may decide the patient can go home that day or the following day. The managed care company decides the patient didn't meet acute care criteria and wants them categorized as an observation patient. It sends a letter saying it will pay the observation rate, but not the inpatient rate."

The dilemma, Miller explains, is that the hospital may decide after having provided treatment that the patient meets observation criteria. Medicare guidelines don't allow switching patients from one status to another, especially after discharge.

"Our corporate compliance director has made a stand that we won't treat patients differently — we won't change their status — because of payer source," she says. "It gets a little gray when there is a contractual agreement and we are willing to accept a lesser payment. What has happened is we have all of these accounts that we agree should have been observation, but we can't change them, and the managed care companies won't send us money because they want a bill that says 'observation.'"

As a result, Miller notes, "there are literally millions of dollars sitting out there that is our money. It's almost like the managed care companies have figured out a way to hold onto it. They know we can't change patient status, but they ask us to."

Although some facilities do change the patient status, she adds, they are risking sanctions from HCFA by doing so. "We have an interpretation that says if you can determine within 12 hours that a patient has been inappropriately identified as an inpatient, and if a physician writes a clarifying order, you can [change the status], but our director of corporate compliance is not comfortable with that," Miller says.

Another complication of changing patient status, she points out, is that the bill would have to be recoded, which means hospital statistics would change. "Even though we treated a patient and provided care, that wouldn't show up to the same degree [in the statistics]."

In one instance where a managed care company questioned the inpatient designation, Miller notes,

the patient, who had a history of colon cancer, spent three days in the hospital getting a work-up, was in severe pain requiring an analgesic pump, and was experiencing rectal bleeding. "[The managed care company representative] asked, 'How much rectal bleeding?'"

The tracking, trending, and reporting database that Baycare created to help manage its denials is so effective the health system may make it available to other hospitals, she says. "We're still tweaking it, but we're very close to being able to offer it."

The software has made it possible for various hospital departments to measure avoidable days and devise action plans for how to reduce them, Miller adds. "The continuum department has goals related to avoidable days, denials, and write-offs, as do patient accounting and patient access services. This is part of 'Impact Care,' our measure of service, outcomes, and cost, for which we set goals every year."

[For more details, contact Martine Saber at (727) 462-7139, martine.saber@baycare.org or Donna Miller at (727) 462-7149, donna.miller@baycare.org.] ■

Access managers blast Medicare appeal form

Join the how-to-do-it debate

A Medicare form that's been around for a while is getting new attention from the Health Care Financing Administration (HCFA) and causing headaches for access managers who say distributing it is an unnecessary hardship.

The Notice of Discharge and Medicare Appeal Rights, formerly known as the Notice of Noncoverage, is designed to give Medicare managed care patients the same rights to appeal a discharge as traditional Medicare patients, but the effort is misguided, says **Jack Duffy**, FHFMA, corporate director for patient financial services at ScrippsHealth in San Diego. "It's the worst thing that ever happened. It's like an informed consent, but I know these patients. They have a limited comprehension of legalese."

Within his organization, Duffy notes, access personnel "are saying nurses have to [distribute the form], and nurses are saying access should do it." If the signed form has to be stored on the patient's chart and copied every time the chart is copied, that raises another logistical concern, he adds.

The notice has been part of HCFA regulations for years but had been "largely ignored for a long time," says **Kathy Warren**, MS, chief operating officer of Qualidigm, a quality improvement organization in Milltown, CT. "The statement in the regulations basically said that a managed care plan had to give patients notice within so many hours of discharge that they could appeal that discharge if they thought they were being discharged too soon."

About a year ago, "probably because one of the advocacy groups noted that it was being ignored," the regulation was resurrected, Warren says, and became a topic of discussion. "HCFA said it had to be done; managed care plans started looking into how it could be done, and people were struggling with how it had to be done."

Managed care plans don't have someone on site at hospitals to present the form to patients, she adds, so the questions became, "Who is going to do it?" and "How will it be done?"

The most illogical thing about the notice, points out Scripps access director **Mollie Drake**, MBA, is that it's supposed to be presented even to patients who are in full agreement with their discharge. "It states that after this date, the insurance company will not pay the hospital bill. Elderly patients may see this and think the two-day stay they've just had is not paid for.

"There is also a real logistical concern," Drake adds. If access services is charged with distributing the form, "this requires that the nursing floor contact access and let them know the patient is being discharged. Then the access representative must look to see if the patient being discharged [is a Medicare HMO patient] and, if so, fill out a form, run to the patient's room, discuss it with the patient, and get a signature on the form."

With luck, she adds, the patient has been informed of the discharge, but that may not be the case. "They may not know they've been discharged yet, so we have to make sure we're not the ones giving that notice.

"It's a horrible procedure that will cause a lot of confusion," Drake says. "I could understand presenting the form to a patient who is disputing the discharge. Even with a regular Medicare patient, we only do this if the patient disagrees with the discharge, so we are going beyond what we do for a regular Medicare patient."

Warren's understanding, she says, is "HCFA is not necessarily enforcing it," but discussions

continue on how to implement the regulation.

Despite repeated calls, *Hospital Access Management* could not get a response from HCFA on the Medicare notice. A Feb. 11, 1999, operational policy letter, currently posted on the HCFA Web site (www.hcfa.gov), addresses the issue. The letter states that "after consultation with beneficiary, managed care plan, and provider communities, [HCFA] revised the model language for the Notice of Non-coverage and [has] changed its name to reflect a more 'beneficiary friendly' notice."

The letter also says, however, that there are "still many unanswered questions regarding proposed changes to our policies for these notices [e.g. timing, staffing difficulties, etc.]. We want you to know that we are committed to addressing all of those concerns and questions before making any changes to the current requirements for the issuance of these notices."

Because the Medicare notice "is a regulation on the books," Warren points out, "HCFA has its neck stuck out. If they don't do something to enforce it, and if someone brings suit because a patient is discharged too soon, it's a no-win situation." ■

Final rule on APCs called mostly positive

Changes reflect comments HCFA received

Generally speaking, hospitals should be pleased with the changes reflected in the final rule on the outpatient prospective payment system (PPS), says **Kevin Quinn**, senior health economist with Abt Associates, a health care research and consulting firm in Washington, DC.

As expected, the Balanced Budget Refinement Act (BBRA) of 1999 mitigated much of the negative financial impact of the proposed rules issued Sept. 8, 1998.

Many of the administrative changes made in the final rule, published April 7, 2000, in the *Federal Register*, reflect the impact of the 10,500 comments the Health Care Financing Administration (HCFA) received from health care organizations, physician groups, beneficiaries, professional organizations, and special interest groups, notes **Laura Frazier**, RHIT, manager of ambulatory patient classifications (APC) solutions for San Rafael, CA-based QuadraMed Corp.

"I think that hospitals got almost everything they wanted," adds Quinn. "There is more money on the table — an overall increase in the budget. A bunch of specific hospital concerns got addressed in the final rule."

Among the pluses for hospitals, he says, are "a remarkable degree of unbundling, an outlier payment mechanism, pass-through payments for medical devices and some drugs, and no allowance built into the budget calculations for changes in coding. Changes in coding are likely to result only in increases in payments, so some payers, when they are doing something like this, build in an allowance for that. HCFA did not."

Unbundling is "where all the action is" when you design a prospective payment method, he says. "If you look at the diagnosis-related group [DRG] payment system for hospital inpatient services, there is one payment for each stay, and within that stay it doesn't matter how many tests are done [or] how many X-rays are taken. DRGs are a relatively bundled system."

The physician payment system, in which physicians bill any one of 8,000 different services, is "the epitome of unbundling," Quinn points out. "A few years ago, people talked about APCs as if they were outpatient DRGs. No one would say that now. HCFA has taken much more of a resource-based relative value scale philosophy, which is how physicians get paid, than a DRG philosophy."

Other positive notes for hospitals reflected in the final rule, he says, include the following:

- A transition period through 2004 during which Medicare will pay hospitals a portion of any losses they otherwise would incur as a result of receiving smaller payments than under prior law.
- Additional protection against adverse effects for rural hospitals and cancer hospitals.
- No control on any increases in utilization of services.
- No checking of physician bills against hospital bills to see if, for example, the physician billed a level 1 office visit, and the hospital billed a level 4 office visit.

"The only place HCFA stood really firm," Quinn adds, "was in its treatment of observation services." **(See related story, p. 66.)**

Not all reaction to the final rule has been positive, however. Overall, the increased payments still put hospitals in a hole compared to where

APC expert answers common questions

Here are the most frequently asked questions regarding the ambulatory payment classifications (APCs) of the new prospective payment system (PPS) for outpatients, with answers provided by Laura Frazier, RHIT, manager of APC solutions for San Rafael, CA-based QuadraMed Corp.

1. Will there be a delay in implementation? There is a legislative mandate requiring implementation of the outpatient PPS. July 1, 2000, will be the effective date for PPS. No justification for a delay has been identified.

2. When were the final rules published? The Health Care Financing Administration (HCFA) made the final rules available for public inspection March 31, 2000. The *Federal Register* published the final rules April 7, 2000.

3. Were there significant changes in the final rules? Yes, there were major changes. The entire APC list was reorganized, including the descriptions of each APC and the organization of HCPCS codes into each APC. The three-digit APC was replaced with a four-digit number for each APC. There are now 451 APCs and four new payment status indicators, for a total of 12. The annual conversion factor for the year 2000 was published, and the relative weights for each APC went through an adjustment as well.

Many of the newly incorporated and covered services listed in the final rule are an addition to the outpatient PPS as a direct result of the Medicare Balanced Budget Refinement Act of 1999, which mitigates much of the negative financial impact for most health care organizations. Other changes were made in response to the 10,500 comments received by HCFA after release of the proposed rules.

4. Will observation services be covered? Observation services will be packaged into the reimbursement for covered outpatient services when provided in conjunction with an APC. There are no provisions in the final rules for observation services to receive distinct payment.

5. Will the codes on the hospital's claim and the physician's codes have to match? In the final rules, HCFA has clarified that the assignment of an appropriate level of service to reflect the hospital's resource use will be based on each individual facility's policy. HCFA states that each facility will be held responsible for following its own system for assigning different levels of HCPCS codes, based on documentation and medical necessity. Furthermore, HCFA states that it does not expect to see a high correlation between the codes reported by the hospital and the physician.

6. Will the compliance program and plan be affected by the advent of APCs? Absolutely. A compliance program and plan are evidence of an organization's commitment to uphold the laws that govern it. A compliance officer's responsibility is one of ongoing education and updating to manifest that commitment. The updates required for implementation of the outpatient PPS are a significant and important part of that effort.

7. What is the most important priority in preparing for the outpatient PPS? Improving operational efficiency requires the participation of all departments that have anything to do with outpatient services. Facilitywide awareness and education is the most important first step.

[For a complete look at the final rule, go to HCFA's Web site at www.hcfa.gov/regs/hopps/default.htm. For more on QuadraMed, call (800) 393-0278 or visit the company's Web site at www.quadramed.com.] ■

they were before the Balanced Budget Act (BBA), according to the Chicago-based American Hospital Association (AHA).

Before the BBA was passed in 1997, Medicare paid hospitals about 92 cents for every dollar of outpatient services performed, the AHA says. The BBA cut that amount to about 82 cents on the dollar and threatened to lower it. The 1999 BBRA stopped the decrease. With the new PPS regulation, the amount of payment will go to about 86 cents or 87 cents for every dollar of outpatient services. And that amount will decrease as "transitional corridor" payments are phased out, AHA officials point out.

"The big question is how well the corridor system will work," says **Eric Zimmerman**, JD, an associate with the law firm of McDermott, Will, and Emery in Washington, DC. Zimmerman

notes that the payments will be made retroactively when hospitals submit the paperwork. "It will be interesting to see how well carriers will implement that and how soon providers will get their money."

Frazier points out that while many of the provisions of the BBRA reduce the negative financial impact, there are still tremendous operational issues facilities will face that have not been mitigated. Even the stated objective of the PPS was revised to capture HCFA's intent, she adds.

Added to the objective of simplifying the payment system while ensuring hospitals are compensated adequately is the phrase, "and encourage hospital efficiency in providing outpatient services," Frazier says. ■

For best training results, seek common ground

'Team success' is the goal at Crozer-Keystone

When you've designed the blueprint for impressive customer service, trained staff accordingly, and even offered some goals and incentives — start all over again. That's the philosophy of **Anthony M. Bruno**, MPA, corporate director of registration and financial services at Crozer-Keystone Health System in Upland, PA. He says consistency is the key to success.

"So many times hospitals roll out programs with punch. They're effective, but then they stop," he says. "They assume people have it. But remember there is staff turnover [and] many other new priorities. People lose sight of the training, and the value of the service gets pushed aside."

When Bruno left his last position, director of health care access management at Philadelphia's Albert Einstein Medical Center, he took with him the commitment to customer service that earned him the 1998 Einstein Award for Customer Service. **(See *Hospital Access Management,* August 1999, p. 89.)**

A recent inservice training program for Crozer-Keystone's patient financial services and admissions department management staff, he says, was designed to make sure employees were on common ground regarding the expectations for customer service. Even the details of the workshop itself, Bruno points out, exemplified key ingredients of impressive customer service: incentives, recognition, and rewards. "We served a very nice, full breakfast, not just bagels, and also a very nice lunch," he says, "so the workshop was geared around recognition and rewards."

Topics at the workshop, which he presented with **Marina Zeccardi**, Einstein's director of service line quality improvement, revolved around a theme of team success, Bruno says. The idea, he explains, is "to pull together not only a team, but one driven by team success. That is, in every encounter we have, whether in our own department, between supervisors, or with another department, we try to ensure the other person's success. It's not just cooperation and collaboration, but [focusing on] how to make the other person successful."

The entire program is based on modeling behavior for employees, Bruno notes. "If [managers and supervisors] treat them well, they will treat customers well. You can't just tell them to do something."

A believer in reminders and educational aids to illustrate his points, Bruno came up with a new tool for the workshop. "Daily Doses for Success: Reminders for Managers" is a list of 24 "simple little things" he says will help managers achieve success and impressive customer service. **(See p. 68.)** The reminders are on colored card stock in a spiral binder that supervisors and managers can keep on their desks and flip to on occasion.

When Bruno spoke to *HAM* about the workshop, he was in the middle of another employee recognition event, the annual National Healthcare Access Personnel Week. Different days featured different treats, such as pretzels, desserts, and a raffle for gift certificates. On International Foods Day, staff members brought dishes representing their ethnic backgrounds, he says.

Zeccardi, whose job description includes improving customer service within Einstein's department of medicine, says she was struck during the workshop with a realization about the participants. "It hit me that there was a common theme," she adds. "In the stress and operational requirements of everyday life, these things [discussed in the workshop] tend to go out the window, yet it's the customer service issues that brought us to this industry.

"We want this every day — a cooperative air, a friendly environment — but we just get overwhelmed," Zeccardi says. "The idea is just to bring it to the forefront."

When she gave workshop participants the example of how managers continue to talk on the

phone or answer e-mail when a staff member comes in with a concern, Zeccardi notes, she got their attention. "How amazing for the staff member it would be if you turned away from the computer screen, closed the file, and said, 'What can I do for you?'" she told her listeners as she illustrated the action for them.

At that point, she adds, "the whole room went quiet. I said, 'See the statement that makes, that feeling of focus, of being on the receiving end of that attention.'" Although it's not always possible for the manager to drop everything, Zeccardi says, an alternative is to say, "Just let me jot off this e-mail, and then I'll be right with you."

One supervisor reacted strongly to the "daily dose" reminder about speaking to all of the staff each morning, she adds. "She put her hand to her mouth and said, 'I never thought about it, but I go past a lot of people on the way to my desk and I don't always say hello or good morning.'"

[Anthony Bruno is putting together a consortium of patient access services professionals to share ideas about customer service and other access issues. For more information, contact him at Crozer-Keystone Health System, One Medical Center Blvd., Old Main Room 301, Upland, PA 19013-3995. Telephone: (610) 447-6104. Fax: (610) 490- 7936. E-mail: Anthony. Bruno@crozer.org. Marina Zeccardi may be reached at Albert Einstein Medical Center, 5401 Old York Road, Suite 363, Philadelphia, PA 19141. Telephone: (215) 456-8348.] ■

Daily doses for success: Reminders for managers

The following is a list of suggestions for improving customer service from Crozer-Keystone Health System in Upland, PA:

1. **Write thank-you's for impressive customer service.** Write appreciation notes to three staff members who exemplify impressive customer service. Follow this model to make it easy:

Behavior: Describe the service behavior that you appreciated, e.g., "I noticed or I heard that you . . . ."

Impact: Describe the consequences for the customer, e.g., "This had the effect of . . . ."

Pinch of empathy: Show an understanding that the employee had to undergo effort, or difficulties, or go out of their way to do what they did, e.g., "I realize it's not easy to . . . ."

Thanks: Explicitly express your appreciation or thanks, e.g., "Thank you. I really appreciate it, and I know your customers do too."

2. **Keep a "great service" notebook on your desk.** Label a notebook "Impressive Customer Service" and keep it by your phone. As you deal with other departments, vendors, and the competition, jot down any customer service idea you think is excellent. For example, maybe a customer service rep says to you: "I'm sorry, but it will be at least a 10-minute wait before I can give your problem my full attention. Would it be all right if I took your number and called you back?" That's a whole lot better than being put on hold for 15 minutes. And you'd probably want to jot this idea down to see if it would work in your department.

3. **Call employees and customers by their names.** "Remember that a person's name is to that person the sweetest and most important sound in any language." — Dale Carnegie

4. **When your employees are swamped, pitch in.** Don't forget the saying, "If we don't hang together, we'll hang separately." Show that you value internal customer service, with you in the provider role and members of your team and colleagues in the "customer" role.

5. **Tell your staff!** Through research, experts have identified the top five phrases that almost always evoke hostility and miscommunication. Avoid them when communicating with employees and co-workers: "You never . . . ." "You always . . . ." "Why did / didn't you . . . ?" "How could you . . . ?" "It's not my job to . . . ."

6. **Take advantage of meetings.** Start staff meetings in ways that help staff recognize their positive service contributions and those of their peers. Ask one warm-up question per meeting and invite everyone to answer it. For instance: "Since we last met, what good example of great service have you seen someone here provide?"

Thank someone publicly for helping you out in a tough situation. Brag about one example of great service provided since the last meeting.

Commend the group on a service strength you noticed in the last week.

7. **Don't use short staffing as an excuse.** Talk with staff about the importance of *not* saying, "Sorry, we're short-staffed." Even though the staff member perceives this to be an honest explanation to a customer, the impact of it is that the patient or other customer loses confidence in the team and the organization. Talk with staff about better and still honest approaches, such as, "I'm so sorry you had to wait. I was helping another patient and it took a lot of time. Now I'm here and want to give you the help you need."

8. **Study slow transactions.** Any time a customer transaction takes longer than it should, ask your staff members to break down the transaction with you. Why did it take so long? Was it a one-time problem or a glitch in the system? What can be done to make sure it doesn't happen again? By learning from your mistakes, you will drastically improve customer service.

9. **Four ways to improve customer service: No. 1.** Stock your customer service areas. Make sure all the supplies your staff need to give to customers (forms, instructions, specimen cups, etc.) are quickly available. There's no reason a transaction should ever be held up because a staff member doesn't have what he or she needs immediately.

10. **Four ways to improve customer service: No. 2.** Often staff are at the mercy of employees in other departments when trying to solve customer problems. Make sure *all* of your employees understand the importance of customer service, and that when staff in other departments call looking for answers, your staff know to give that call top priority.

11. **Four ways to improve customer service: No. 3.** This week, talk with two staff members whose role in customer service you would like to strengthen. Ask them outright how they see their role in customer service in their particular jobs. Help them pinpoint who their customers are, what's important to their customers, and how they can provide this in their roles.

12. **Four ways to improve customer service: No. 4.** Ask staff to bring in cartoons that illustrate the importance of service behaviors. Display these on a bulletin board or in a public area. They raise awareness. Offer a candy bar to each person who brings in a relevant cartoon.

13. **Respect people's differences.** Organize an international luncheon and ask employees to bring in their favorite ethnic dish. Not only will you have a delicious meal, you will spark some interesting conversation as everyone introduces his or her entree.

Try putting together a calendar marking important events in international history. Acknowledge accomplishments made in different cultures. Let your employees take pride in their own backgrounds while educating others.

14. **Think positively.** Griping, bad-mouthing, and complaining rarely accomplish anything. All they do is drag people down. Be conscious of what you are doing and saying. Just for today, instead of talking about your complaints, write them down on a to-do list. Turn these aggravations into action.

15. **Good starts.** Do morning rounds just to say good morning to all of your staff. Don't mix in any business issues, just smile, make eye contact and say hello. Express a few words of interest in the person such as, "How was your weekend?" or "How are the kids?" Even comments about the weather, like, "Isn't it a beautiful day?" or "Did you get caught in all that rain?" serve as good ice breakers.

16. **Invest in community service.** Hospitals and health care institutions are not only important to their patients, they are members of a local community. Encourage your department employees to invest their time and attention in the neighborhoods surrounding your facility. Sponsor a clothing drive for a local shelter, collect toys for young children during the holidays, or make crafts for a nearby nursing home.

17. **The 10-10-10 principle.** Remember, it takes $10,000 to get a customer, 10 seconds to lose one, and 10 years to make the problem go away. Simple mathematics tell us that it is more efficient and cost-effective to *keep* the customers we have.

18. **Speak up.** Starting today, don't walk past a problem, error, or example of shoddy service

without commitment or action. Take responsibility. Instead of letting poor quality happen, every person needs to step in and do what he or she can do to improve things.

19. **Become a quality advocate.** Dare to go public with your commitment to quality performance and impressive customer service. Be a positive and inspiring influence to improve quality. Because change — even change for the better — can be tiring, it takes commitment. If you're committed to quality improvement, then express your commitment by being willing to say, "It's about time" and "I'm glad this is happening here" and "I'm going to believe it will work until it's proven otherwise."

20. **Pursue continuous improvement in yourself.** Learn, read, and expand your skills so that you can be ever more effective in making quality happen. To improve your contributions to quality, you can take steps to strengthen your job skills through reading, attending educational programs and training sessions offered in your organization, asking questions, and learning from co-workers. If you're open to self-development, you can find ways to become more effective in your job and an ever more valuable contributor to your organization's quality track record.

21. **Expect the best.** The best leaders believe that no matter what their role, people can achieve the high standards they set. It's called the Pygmalion effect, a belief so strong that even if others don't believe in themselves initially, the leader's belief gives rise to self-confidence, to a belief that "Yes, I can do it." Like it or not, our beliefs about people are broadcast in unconscious ways. When leaders expect people to achieve, they do. When they label people underachievers, this message comes across, and performance suffers.

22. **Tell a story.** Storytelling is one of the oldest ways to convey values and ideas. Good stories move us, touch us, teach us, and cause us to remember. The story provides a behavioral map. While the live example is the most powerful way to publicize what people do to exemplify values, newsletters, annual reports, ads, even voice mail and e-mail can teach positive stories about what people do to exemplify our values.

23. **Celebrate together.** Many of us are reluctant to recognize people in public, perhaps fearing that it might cause jealousy or resentment. But if you are genuine, this doesn't happen. Most of us want others to know about our achievements, and the public ceremony does that. It also lifts people's spirits and brings people together.

24. **Hang a "Poster of the Month."** Ask staff to contribute ideas for posters and be responsible for hanging a different poster each month to reinforce the behavior in focus. Consider having a poster contest as one way to generate great posters. Invite someone with graphic design skills to create a banner and hang it in a very public area. ■

Providence patients preregister in cyberspace

'Vocal' minority use it so far

Since August 1999, patients at Providence Health System in Portland, OR, have been able to preregister for admission or outpatient services via the Internet. The trick, says **Barbara Wegner**, CHAM, regional director of access services, is getting them to do it.

"Some people are using it, but it hasn't caught on like wildfire," Wegner explains. Providence is publicizing the new preregistration option through local newspapers and the newsletters it sends to its physician group, she adds. Other plans include placing cards explaining the service in physician offices and posting notices around the hospital and in access interviewing booths, Wegner notes.

Providence also is working to make the process more user-friendly, she adds. "There is a lot of information to be entered, a lot of screens you have to go through."

As people become more familiar with the idea of sending information across cyberspace, usage will increase, predicts **David Hardy**, information systems coordinator for regional access services. "It's just like making purchases on the Internet. Initially there is not a lot of volume, but it just takes time to catch on."

Web surfers who do choose to use the Internet option have made it clear that's the only way they want to communicate, Wegner points out. "We found out at the beginning, when we were calling people back to clarify information, that

those patients expected to be contacted via the Internet as opposed to a phone call. They were pretty vocal about it."

One access employee has been designated to handle the Internet preregistrations, which come in to the central access services department, a kind of call center, she says. "They are checked every day. I would say this is a starting point [for other Internet services]. We probably would like to get into doing appointments. The physician offices may be interested in that."

One possibility being discussed, she says, is having patients enter their demographic information directly into the computer system so access personnel wouldn't have to re-enter the data. Both Wegner and Hardy say that idea presents a number of challenges. "One obstacle would be making sure the data entry was correct," Hardy points out. "Having a person review what is entered is invaluable. If the patient put in the name of a physician that doesn't exist, for example, that would confuse our system."

Another concern, Wegner notes, is the likelihood that multiple patients will have the same name, in which case such direct access could compromise a person's privacy. "I could go in and call up my account, but there might be a number of Barbara Wegners in an index of 3 million. I could be looking at another person's entire medical history."

There is little if any reason, however, to be concerned about the security of the pre-registration information that is sent over the Internet, Hardy emphasizes. "People are still leery about putting personal information on the Internet, but there is the same level of security as with an Internet purchase." The 128-bit encryption that is used to protect the transmission of registration data is by far the most secure of the two basic versions of encryption, the other of which is 40-bit, he says. "There is a huge difference between 40-bit encryption and 128-bit encryption. Some experts have estimated it would take 1,019 years to break a 128-bit encrypted message. This, for practical purposes, should be considered safe."

Although it's common for people who use the Internet to have that level of encryption on their Web browsers, those who don't may upgrade on the registration screen, Hardy adds.

(Editor's note: To check out the Providence Health System preregistration process, go to the health system's Web site, www.providence.org, and look for the Web registration link.) ■

NEWS BRIEFS

Take a practical approach to 21st century access

A jointly sponsored conference of the National Association of Healthcare Access Management (NAHAM) and the American Association of Healthcare Administrative Management is scheduled for Oct. 11-13 at the Renaissance Hotel in Washington, DC. The conference, called "A Capital Vision: Practical Approaches to Patient Access and Accounts Management in the 21st Century," is expected to draw more than 800 attendees, according to NAHAM officials.

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There will be two educational tracks — patient access services and patient financial services — covering 24 concurrent workshops over three days. In addition to the concurrent workshops, three general sessions will be offered, and there will be opportunities for networking, sharing experiences and ideas, and socializing.

The conference also will offer participants the opportunity to earn recertification contact hours and nursing credits and to take the certified hospital access manager certification examination.

For details, call NAHAM at (202) 857-1125 or e-mail info@naham.org. ▼

OIG software report looks at claims risks

Although Medicare claims software written for commercial distribution to a large audience poses little risk of producing erroneous or false claims, proprietary software appears more likely to pose some risk of misuse or fraudulent use, according to a report released by the Office of the Inspector General (OIG) in Washington, DC.

The OIG decided to review software literature and claim preparation processes because of the vast numbers of claims electronically submitted to Medicare. The report, "Medical Billing Software and Processes Used to Prepare Claims" (OEI-05-99-00100), found many potential problems with submission of the claims, including:

- Medicare cannot identify most of the clearinghouses and billing agencies submitting claims because most use the physician's or medical supplier's billing number and submitter number.
- Medicare can't determine whether claims enter from an authorized biller's site and computer or from unauthorized sites and computers.
- Billing companies, their employees, and employees of providers with access to patient and provider information need to access the Medicare system.

The OIG report made these recommendations:

- Identify and register all clearinghouses and third-party billers. That would provide an audit trail.
- Improve safeguards to ensure electronic claims are accepted only from authorized sites and terminals.
- Educate providers about their liability for erroneous claims submitted to Medicare using their provider numbers. ■

ACCESS FEEDBACK

AM seeks benchmarks to improve preregistration

Liz Kehrer, CHAM, manager of patient access at Centegra Health System in McHenry, IL, is looking for health care facilities that have been identified as "better performers" in preregistration. "I'm looking to expand our facilities' preregistration services to include insurance verification, precertification, and financial counseling for scheduled services," she says. "I'm also looking to include collection at time of service."

If possible, she adds, Kehrer would like contact names for the "better performer" organizations.

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