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How to create or expand a call center: Experts share their tips

It's important to have a vision, UPMC director says

With reports touting the financial and customer service benefits of call centers, it's no wonder that more hospitals — often under the aegis of their access departments — are looking either to establish a call center or to expand the capabilities of an existing one.

According to research by Solucient (www.solucient.com), the average caller to a hospital call center generates 150% more revenue for the facility per year than the average hospital patient — $13,848 in hospital charges vs. $5,524. The average retention rate of call center customers for hospitals in the Solucient study — which looked at 11 call centers serving 25 hospitals — was 70%, compared to 46% for other patients.

With results like that, it makes sense for access directors to consider whether a call center is right for their organization and, if so, what form it will take. **Gillian Cappiello**, CHAM, senior director of access services and chief privacy officer for Swedish Covenant Hospital in Chicago, agreed to share with *Hospital Access Management* some of the questions she is asking as her hospital explores the possibility of expanding its call center. *HAM,* in turn, asked a patient access director who oversees a successful call center as well as two consultants who have helped create them for the benefit of their experiences. Other aspects of call center development will be discussed in future issues of *HAM.*

Q. The first thing we want to figure out is what we want the call center to look like. We have appointment scheduling, community event scheduling, and physician referral included, but what are the other opportunities?

A. It is important to have a vision when designing a call center, says **Georgina Trunzo**, director of patient access services for the University of Pittsburgh Medical Center (UPMC), but it may be necessary to scale back from one's original vision in order to get something up and running.

"I wanted to keep the scope reasonable so we could achieve success,

and I didn't want to get in over my head," she explains. "We focused on six of our health system's 18 hospitals, and do reservations, pre-registration, insurance verification, pre-certification, and authorization of referral management for inpatients, same-day services, and high-dollar outpatients."

"At the same time," Trunzo adds, "we work collaboratively with the physician services division, which is on the same floor, on every project we touch to make sure we are not being redundant."

Rather than focusing on how many of the 18 hospitals joined the call center, she notes, it was more important that patient access policies and procedures — including such things as job descriptions and methods of cash collection — were standardized across the system.

Trunzo oversees a financial call center, and she notes that programs such as Ask-A-Nurse are part of a completely separate consumer call center, and transfers from other hospitals are handled in a medical staff call center. Hospital operators are part of the medical call center, she adds, while calls from people wanting to make physician appointments are handled by the consumer call center.

At one point, Trunzo says, UPMC looked at centralizing bed management in the financial call center, and she contends that "it would be great to include everybody in one place, as much as you can get together."

"Our original vision was to include all in one," she adds, "but it got so large we would have still been talking about it two years later. We didn't want to just be talking about it, we wanted to be showing results."

John Woerly, RHIA, MSA, CHAM, a senior manager with the Indianapolis-based consulting firm Capgemini, who worked closely with Trunzo in developing UPMC's call center, says he has developed technology and process methodology for the following call center — or to use the more sophisticated term, customer relationship management (CRM) — applications:

- Physician referral
- Consumer referral
- Community education (class registration)
- Marketing fulfillment (smoking cessation class, pediatrics campaign, etc.)
- Demand management/disease management ("Ask-a-Nurse")
- Clinical and financial clearance (pre-registration, insurance eligibility/benefit verification, pre-certification/authorization, PCP referral, medical necessity review, and financial counseling)
- Patient support center for case management/utilization review activities
- Bed management (including medical necessity and appropriateness of care review)
- Enterprise scheduling (outpatient, preadmission testing and surgery scheduling)
- Customer service (billing/collection response and problem resolution)
- Switchboard
- Physicians' answering service

"These services can easily serve multiple hospitals at an enterprise level," Woerly notes. "It is important to know your market and the desired service outcomes."

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Editorial Questions

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Trunzo agrees, noting that those looking to develop call centers should "outline very carefully the scope and the results you want to achieve."

Q. What's working for the organizations that have call centers? Is there a service they've tried and now advise against, for example?

A. The ease of communication with the customers is working well for the call center, says Trunzo. "Physician offices — a large customer for us — know that they can call one area and that everything comes to one location. When they submit a reservation, they can communicate electronically, they can pick up the phone, or they can fax it over."

"It's so much easier to manage the financial piece when it's centralized and off-site," she notes. "All the employees are right here on half a floor." When employees performing these functions were in individual hospitals, Trunzo adds, they were the first to be called on to fill in for other employee vacancies."

One of the challenges, she says, is making sure that everything is done in a timely manner for those who are on-site at the hospitals and dependent on call center staff for the pre-arrival functions.

"There are still consents [for example] that need to be signed, or patients we have financially counseled who will bring money [to the point of service] instead of paying by credit card, so the sites rely on us to make sure all of the information is in the system," Trunzo says. "We can never take [those communications] for granted. Sometimes there are printing glitches."

Woerly adds that while there are many services that can be offered through call centers, they should be looked at through the lens of these questions:

- What is the desired outcome?
- What is the return on investment (ROI)?
- What is the budget, and how do we prioritize program offerings?
- What is the level of administrative and clinical support?

Q. We have a physician answering service [that is] run through the hospital switchboard operators. Should we consider moving that to the call center?

A. "There is no right or wrong answer to this question," Woerly says. "It is highly dependent upon the level of service that you desire to handle. I have had [physician answering services] in a call center environment."

Although it is desirable to have all services offered 24/7, it is not cost-efficient in most cases, he notes. "However, by combining like functions in a consolidated call center, you can blend various job offerings and staff skill sets."

It may not be possible to effectively train a switchboard operator to effectively perform scheduling and financial clearance functions, in addition to his or her own duties, Woerly adds, but there may be other combinations of work in which staff can be cross-trained.

"This is important for after-hours and weekend coverage," he says. "Economy of scale and full deployment of resources (people, processes, and technology) is the key."

Q. Because our physician referral telephone number is widely advertised in the community — it might be given out on a radio station, for example — that number gets a lot of calls that don't have anything to do with physician referral. How do you handle that issue?

A. Different services require different phone numbers to best serve each independent population, Woerly points out. "You don't want to mix switchboard calls [transactions usually conducted in fewer than 30-40 seconds] with consumer referral calls, which may take five to 10 minutes. You need to blend various employee skill sets and call requirements.

"If you are serving multiple communities, you may need different numbers for each community, [especially] if there is sensitivity within the community that 'business is being taken out of our community,'" he adds.

Q. What kind of technology are organizations using?

A. Capgemini customers are using "all levels of technology — from typical phones to full CRM technology," says Woerly. "Databases of information are essential."

At UPMC, the information flowing between the physician system and the hospital system has made for a lot of improvements, Trunzo says. "We also have medical necessity software up and running, and we're going to a point-and-click front end, where the screens are more user-friendly."

In addition, she notes, there are many direct connections with payers, whereby insurance information automatically populates UPMC systems.

Also, Trunzo says, "we're working with a company now to have a predictive dialer for pre-registration to hook us directly to patients so

we can contact them and put codes in if we need to call them back. That's in the process of being implemented."

"We're always looking at giving staff tools to do their job," she adds, "because we're not increasing staff and volume is not going away."

Q. Outsourcing is huge right now, and we're hearing more about it in regard to call centers. I definitely don't want to outsource. I think it takes away from the personalized approach that is one of our distinguishing features as a stand-alone organization, but that might not matter so much with a large hospital system. What are your thoughts?

A. Outsourcing can be very successful *if* you partner with the right resource, Woerly says. "It is up to you to do due diligence to ensure that you have selected the best resource. You can also establish your own scripts, key performance indicators, etc., to ensure that personalized service is delivered."

A combination of internal and outsourced services may be beneficial, he adds, especially for after-hours and weekend coverage.

Trunzo says she is not a fan of outsourcing call center functions to an outside vendor, although she considers the hospitals served by the call center to be outsourcing to her. "If it's internal to the organization," she adds, "I think it's great!"

Q. There's some pretty compelling evidence for the positive impact of call centers on hospital revenue. According to the Solucient report, each call represents a significant amount in downstream charges. How are those who have call centers tracking the financial benefits?

A. Depending upon services offered by the call center, Woerly suggests tracking various performance indicators, including one or more of the following:

- **Length of stay —** Case management and capacity management strategies should drive length of stay down, he says.
- **Accounts receivable (AR) days —** Good clinical and financial clearance procedures will positively affect AR days.
- **Denials** — Good clinical and financial clearance procedures will reduce clinical and technical denials.
- **Increased patients** — The physician and consumer referrals should be tracked against the number of new patients coming to your physician offices, clinics and/or hospitals. This can be tricky to accomplish, Woerly says, but it is important to measure increased revenues generated from these services as well as various marketing programs.

At UPMC, the financial benefits have been dramatic, Trunzo says. "Denials have been reduced tremendously in the past two years — to 1.8% of total charges — and that's just what was denied the first time. We have an actual write-off rate of only 0.3%."

In the past year, she adds, AR days are down 14 days to 52. While the improvements are due in part to successful partnering with the business office and other factors, Trunzo says, "they wouldn't have happened if [services] were not centralized into a call center."

Q. What kind of training programs have been developed? I'm assuming customer service and telephone skills are addressed, but what about other areas of training?

A. "Train! Train! Train!" is the operative phrase when it comes to call centers, suggests Woerly. It's important that employees fully understand the programs that are offered, he says.

"If there is a smoking cessation class that they are scheduling for, have representatives from that department talk to the staff and explain the program. The more contact the call center employees have with their internal customers the better."

Medical terminology also is very important, Woerly adds. "In some cases, registered nurses and other clinical staff should be blended into the staff model. Again, this is dependent upon what programs are added to the call center."

At UPMC, notes Trunzo, the call center has its own systems and training development division on-site, with four trainers who are responsible for training call center staff — as well as all patient access staff — in learning the admissions-discharge-transfer system, insurance and customer service skills, etc. Each employee receives 12 hours of continuing education per year, and all new employees receive two weeks of training.

Each year, she adds, call center employees receive a manual that reviews policies and procedures, customer service standards, goals and objectives, and other pertinent information. They also attend monthly meetings to keep up to speed.

In addition, she says, "we review productivity weekly with everyone and also have random audits (so many per employee, per month) to

One-on-one training model for improved call centers

Help reps feel good about job

One-on-one coaching is a new aspect of call center training that is as important as the usual focus on customer service skills and keeping the calls flowing in a timely manner, says **Katherine Dean**, SPHR, a partner in Banks & Dean, an international professional services firm based in Toronto.

One-on-one, constructive coaching of call center representatives should be a training priority, and organizations should provide supervisors with the necessary skills to do it, says Dean, whose firm specializes in selection and retention solutions for call centers.

The idea is to coach behaviors, add to skill sets, and make the representatives feel better about what they do, she says. "It's giving them the skills to understand how to handle calls [and] how to meet needs [that are] balanced with the productivity requirements of the call center."

The call center training model should not be a punitive one, but rather one in which supervisors are "definitely appreciating what has been done right," Dean says. "[Supervisors] should ask reps what they feel they have done right and what they would do differently next time, explain what the supervisor heard [in observing the call], and work collaboratively with them on building effective skill sets."

"It's about asking, 'How can we construct some action plans that will make a difference?'" she adds.

Working in partnership with Austin, TX-based Interim Leadership Solutions, she explains, has heightened her awareness that it is not enough to simply provide training to call center employees.

This coaching by supervisors is not just about the hard skills — specific, more active questions, for example – but has to do with "the message behind the message," Dean continues. "It's having the rep feel it's not about meeting numbers — it's helping them get better at what they do."

The desired response from the employee is, "I can feel good about getting better at what I do, and I will be recognized for it," she says. "That's a model change."

In this approach, Dean adds, the supervisor might say, "You were asked this question and didn't have the answer. What would you differently?" to get the employee thinking about that. Then, she says, the supervisor could add, "Here's what I suggest, and here's a reference you can look at that might help."

"There needs to be an understanding that supervisors are [not just] key to reinforcing in a constructive way the old kind of performance," Dean emphasizes, "but that they need to carve out time in their schedules to make [the new approach] the priority that it is."

Call centers are the face of the hospital to patients who start getting impressions when they make that first call, she points out.

"In the world of creating a competitive advantage in patient care, a perception of being served well is very critical," Dean adds. "I would suggest call centers can import that by providing supervisors with not just the hard skills, but with the soft skills to understand how to coach efficiently and change behavior in a way that is a positive experience for both coach and representative."

[Editor's note: Interim Leadership Solutions can be reached at (512) 419-7585.] ■

look at accuracy."

Customer service and telephone skills are addressed annually, with a 2½-hour presentation that includes a test, Trunzo explains, "and there is not a month that goes by that we don't focus on some aspect of customer service."

Because of the crucial importance of telephone skills, call center employees are observed during calls to see how the person's voice sounds and how she identifies herself, she points out. "The focus is on treating each customer with respect."

Employees who excel receive letters from the vice president or gift cards as part of the organization's Rising Star program, Trunzo says. "Employee recognition is key with us."

Katherine Dean, SPHR, a partner in the Toronto-based international professional services firm Banks & Dean, notes that training in such customer service skills as active listening and how to keep a timely call flow while also meeting the customer's needs is critical. But she says her firm, which partners with Interim Leadership Solutions of Austin, TX, finds that another aspect of training is equally important.

"A key issue is helping supervisors find the time in their schedules to coach [call center] representatives," says Dean, whose firm specializes in selection and retention solutions for call centers. "Coaching of reps [provides] one of the best returns on value."

Dean suggests that call center managers make coaching a priority and then determine how best

to do it. **(See Coaching basis of new call center model on p. 113.)**

Q. What about the use of consulting services for best practices, gap analysis, etc., in creating call centers?

A. UPMC worked extensively with Woerly and other Capgemini consultants in the development of its call center, says Trunzo. **(See *HAM*, June 2002, p. 61.)** Capgemini has devised a four-step progression for a call center, with increasingly complex technology at each higher level and was helpful, she says, in "looking at what we could do [initially] and what we may look at in the future."

More recently, Trunzo notes, UPMC has worked with Chicago-based Jeselnick & Associates, which has provided assistance in productivity reporting/technology, such as the predictive dialer system for pre-registration, and with denial management initiatives.

"Their major focus is on revenue cycle management," she adds, "and they have primarily been working on the patient accounting side, but have worked as a team with me on the front end as well."

Woerly notes that the use of consultants is "dependent upon internal resources, sophistication of the desired program, and time frames to implement."

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HIPAA privacy violation leads to criminal conviction

Use case in training, lawyer advises

A HIPAA-related criminal conviction has drawn attention to the seriousness of violations regarding protected health information and should be used as an object lesson in access training initiatives, suggests **Michelle Masucci**, JD, counsel in the health services group for the law firm of Nixon Peabody, LLC, in Garden City, NY.

The case also focuses attention on the national problem of identity theft and how it can impact access services.

A Seattle man pleaded guilty Aug. 19 in federal court to wrongful disclosure of individually identifiable health information for economic gain, marking the first criminal conviction in the United States under HIPAA's health information privacy provisions, which became effective in April 2003.

Those provisions made it illegal to wrongfully disclose personally identifiable health information.

Richard W. Gibson, 42, of SeaTac, WA, admitted in a plea agreement that he obtained a patient's name, date of birth, and Social Security Number while an employee of the Seattle Cancer Care Alliance, and that he disclosed that information to get four credit cards in the patient's name.

Gibson, who was fired shortly after the identity theft was discovered, also admitted that he used the cards to incur more than $9,000 in debt in the patient's name. The FBI investigated the case.

At a hearing scheduled for Nov. 5, U.S. District Court Judge Ricardo S. Martinez will determine whether to accept Gibson's plea agreement. If the plea is accepted, the judge will determine Gibson's sentence within the range of 10 months to 16 months set forth in the plea agreement.

What's really interesting for access professionals about the case is the training opportunity it provides," says Masucci, who, in addition to providing HIPAA counseling, has worked with clients on training and policies and procedures.

Although access employees who receive training on the HIPAA privacy rule have a theoretical understanding of how it applies to them, she points out, "I'm not sure there is an awareness that they can be subject to criminal charges."

In addressing HIPAA privacy and security issues, health care organizations do what they can to keep employees from wrongfully using private health information, Masucci says, "but once you've given them access to the information, you can't put enough safeguards in place to truly [counteract] people who are intent on breaking the law."

The case provides "a little wake-up call," she notes. "It lets them know there are real, personal consequences for them — not just for the organization. It really is a very concrete example."

Identity theft affects access

Identity theft is a huge issue, and one that is impacting the way access departments operate, notes **Gillian Cappiello**, CHAM, senior director of access services and chief privacy officer for Swedish Covenant Hospital in Chicago.

"We have identified several cases of identity

theft," she adds, "usually, when the victims receive a bill for services they never had, and tell us they had their purse or wallet stolen. It's very distressing for the victims, and they are often concerned that they have incorrect health information in their medical record and on record with their insurance company."

Dealing with such cases requires a lot of explanation and reassurance that everything is cleared up, and that the record has been properly identified, Cappiello says.

It is a bit harder to identify patients — and makes more work for registrars — when people, in the name of caution, refuse to give the hospital a Social Security number, she notes. But she says the extra security is worth the trouble. "I think Blue Cross and some other insurance companies have the right idea in using a different number for the insurance policy number."

Swedish Covenant has held a seminar, which was conducted by the Chicago police department, for its employees and another for seniors in the community on how to protect themselves from identity theft, she says.

It's a crime that can have devastating and lasting consequences, Cappiello adds. "When the victim is ill and dealing with so many other issues, it's the worst kind of crime, and the penalty should be the maximum allowable."

While news reports on the Seattle case didn't mention whether the man's employer did employee background checks, she adds, "that is certainly one step that can help."

"Too many Americans have experienced identity theft, and the nightmare of dealing with bills they never incurred," U.S. Attorney John McKay said in connection with the Gibson conviction. "To be a vulnerable cancer patient, fighting for your life, and having to cope with identify theft is just unconscionable. This case should serve as a reminder that misuse of patient information may result in criminal prosecution." ■

Telecommuting 'win-win' for Carolina health system

Productivity and morale boosted

A telecommuting project in the pre-services department at Carolinas HealthCare System in Charlotte, NC, is reducing the amount of work time lost to bad weather and delighting employees who find themselves well suited to working at home.

"We have a visionary group vice president, Oren Wyatt, who has been reading articles about how people liked working at home," explains **Katie Davis**, CAM, assistant vice president of patient registration with responsibility for three acute care facilities in Mecklenburg County as well as for the system's pre-services area. "After a couple of snowstorms, when we had difficulty getting employees in, he began talking about the possibility of having some of the pre-service staff telecommute."

"In September and October of 2003," she adds, "we sent home three of our most productive employees — two from insurance verification and one pre-registration person — and it's been really good." The following January and February — when snow was making travel difficult for other staff members — the telecommuters were able to work every day, Davis notes.

There were very few technical issues involved in establishing the home workspace, she says. "We set them up with a computer, a fax/copier, and a shredder, and put in phone lines."

The implications of HIPAA privacy rule were made clear to the participating employees, Davis points out.

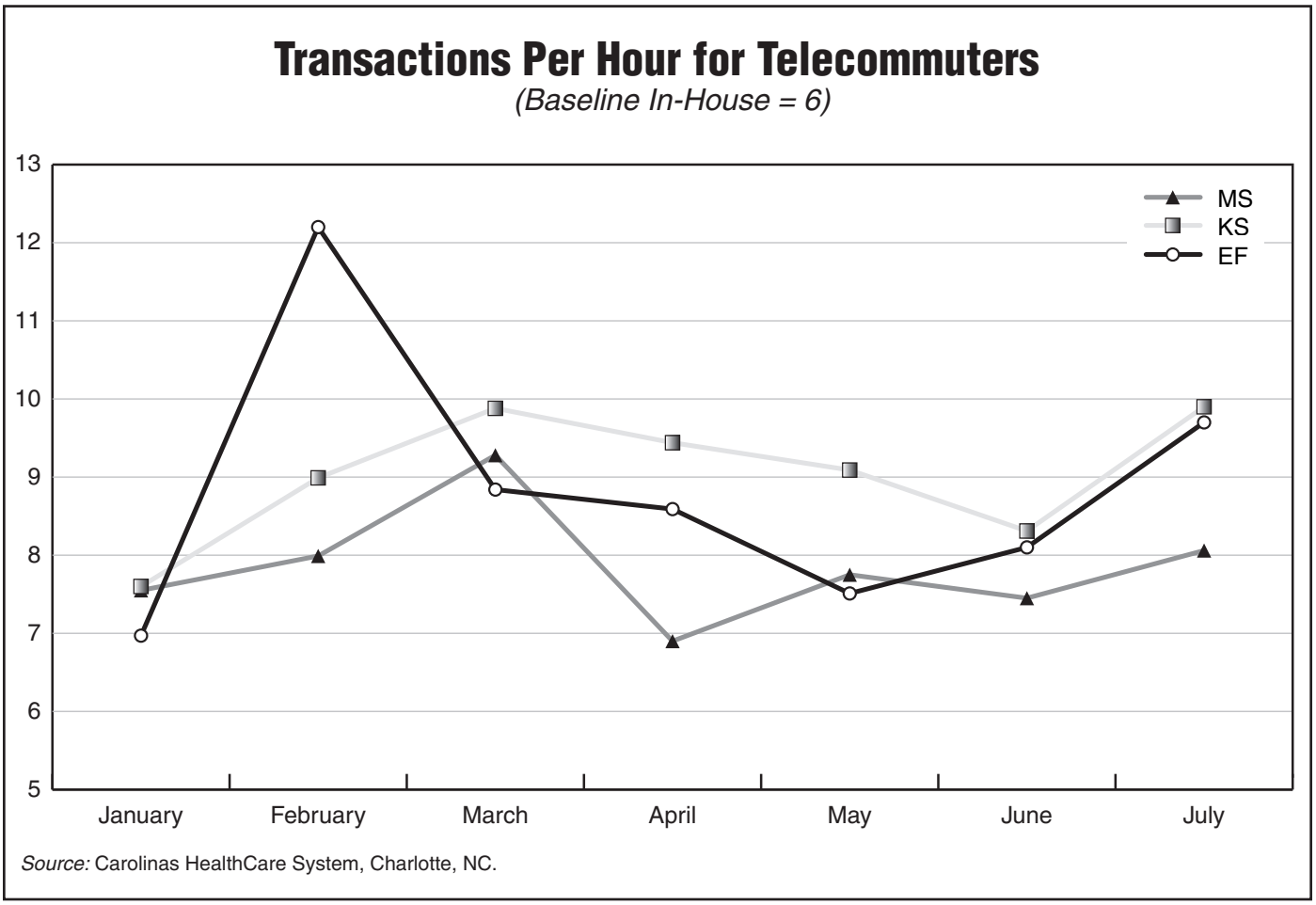
"They needed to understand that they had to have a room to work in where the door could be closed and things could be locked up," she adds, "because they were going to be using health information that could not be shared."

The pre-registration employee, for example, would have to print a surgery schedule, work from it, and then shred it at the end of the day, Davis notes. "If the employees had company, they would have to make sure that everything was put away."

An unexpected benefit has been that the productivity of the home-based employees has noticeably increased. "We monitored them until the first of the year, and then we started measuring. We're very pleased." **(See transactions per hour chart, p. 116.)**

By mid September, two more pre-services employees had begun working at home, plans were in place for two more to begin in October, and another two in November, for a total of six additional people in the telecommuting program by the end of the year, out of 56 employees in the department.

One of the original three participating staff



members was initially hesitant about working at home, Davis says. "She said she really needed to think about it — she was afraid she would miss being around people — but then she said she wanted to give it a try."

Now, Davis adds, she believes that all three employees would be upset if they had to return to the office setting. "They really enjoy what they are doing."

In addition to being able to work during bad weather, one of the advantages is that the employees are more productive at home, she says. "In any area with a large number of people, there are a lot more opportunities to be social."

Employees must work in the department at least a year before they are eligible to participate in the telecommuting program, Davis says. Those who do work at home are required to come to the office every other week for staff meetings.

"If for some reason the equipment is down, or there is an accident and the power to their homes is cut off," she notes, "they understand that they are to come back to work at the facility."

The department's managers visit the homes of those who commute about once a month to encourage a sense of connection. "We don't want them to be like islands out there. We also include them in any celebrations we do — not just at the holidays, but when we meet our goals and have pizza parties."

There is no specific plan for how many pre-services employees will ultimately become telecommuters, she says. "We'll just send some more and see how that goes." The expansion won't be limitless, Davis notes, "because there are those who prefer to be away from home to work."

Neither the potential savings nor the costs of space were driving forces behind the project, she says, although they would be nice side benefits. "What's driving this is employee retention."

With the same view in mind, opportunities for employee flextime already were in place, Davis explains.

"We have employees who rotate schedules and who can work four 10-hour days. Everybody can't be off at the same time, but they can go to the manager and, if the request is reasonable, we'll try to do it."

Pre-services employees begin work as early as 6:30 a.m. and as late as 12:30 p.m., she says, with

a closing time of 8:30 p.m. Extended hours are a "win-win" situation, Davis notes, since it's usually easier to reach people in the evening hours.

"That's one thing we are trying to do here — to make it win-win for both employees and Carolinas HealthCare System," she adds.

"The employees know what it takes to get the job done far better than the managers or even I do. We appreciate their input, take it seriously, and if they can come up with a better way, we'll do it."

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IL consumers get access to hospital 'Report Card'

Will other states follow suit?

Illinois hospitals are in the process of developing procedures for fielding questions about the Hospital Report Card Act, an Illinois law that became effective in January.

As the first point of contact for most patients, access departments are likely to feel the impact as consumers make use of their increased ability to get answers to a variety of questions about hospital operations.

The law, which is the first of its kind in the country, gives Illinois consumers direct access to comprehensive information about nurse staffing levels, patient outcomes, infection rates, and mortality rates in every licensed hospital in the state.

The bipartisan measure provides that some staffing and training information will be disclosed by hospitals upon request, while additional nursing and nosocomial infection data will be reported to the Illinois Department of Public Health (IDPH), which will release the information to the public.

Law represents landmark change

The Illinois Hospital Association (IHA) described the Hospital Report Card Act as "not only a landmark change for consumers in Illinois, but for hospitals, their medical staff, the professionals hospitals employ, and the IDPH."

The law could potentially spread to other states, suggests **Liz Kehrer**, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL. She says "due to recent suspicious inquiries," it became necessary for her hospital to develop a protocol for responding to questions inquiries regarding the report card.

Facilities must have a process in place to meet consumer needs in accordance with the law and, at the same time, not jeopardize their security in any way, Kehrer points out. The following guidelines have been developed at her hospital:

- If the person inquiring about staffing is a current inpatient or a family member of a patient, the information should be provided them as requested.
- If the inquiring individual is associated with the media, the inquiry should be routed to the marketing department, which will respond to the request.
- For all other requests, take the person's name and address, and advise that you will respond to the inquiry by mail within 24 hours.

According to a summary by the IHA, Illinois consumers have access to the following new information under the law:

- Unit staffing schedules
- Nurse-patient assignment rosters
- Hospital-specific methodologies to determine and adjust nurse staffing levels
- Records of staff training
- Nursing coverage, reported in standardized units
- Select hospital-borne infections based on Centers for Disease Control and Prevention definitions and associated with burdensome consequences for the patient, as well as high treatment costs
- Mortality data that hospitals have been submitting for years to the state that will be appropriately risk-adjusted, so that any comparisons will be valid
- An annual progress report on the act's prescribed activities to the General Assembly

Whistle-blower provisions in the law provide immunity from employer actions for hospital employees who, in good faith, disclose activities that they believe may pose a risk to the health, safety, or welfare of hospital patients or the public.

To qualify for immunity under the act, employees must provide to their managers a written notice of the problem and a reasonable period to address the concern. In turn, the manager is obligated to respond in writing within seven days, acknowledging that notice was received. ■

Hospitals given suggestions for reducing terrorism risk

IDs and access restrictions advised

A recent posting on the web site (www.medlaw.com) of EMTALA and risk management specialist **Stephen A. Frew**, JD, warns hospitals to assess their vulnerability to acts of terrorism and suggests some precautionary measures.

A contribution to the site from the Illinois law firm Sorenson, Wilder & Associates points out that by the very nature of their business, hospitals become likely targets for secondary hits following an initial attack elsewhere in the community.

Hospitals should upgrade security and emergency preparedness plans to address this threat, the firm advises, and offers the following suggestions:

1. Develop and establish tight controls to prevent unauthorized access into the facility, including keeping unauthorized vehicles from entering the hospital campus during a community disaster.
2. Require and enforce the use of staff IDs for *all* staff and physicians, regardless of title or position held.
3. Require all vendors to report to the purchasing department for an authorization badge. During a community disaster, refuse admittance to any vendor not delivering emergency supplies.
4. Coordinate your hospital disaster plan with the community disaster plan. Make sure emergency providers (police, fire, emergency medical services) understand your plan, and that you understand how your plan integrates into the community Incident Command System.
5. Educate employees to report any suspicious persons or activities they observe in and around the hospital campus.
6. Do not expect local police, fire, or emergency medical services personnel to be an available resource, as they may very well be committed at another location. Develop your plan to be self-sufficient.
7. Keep nuclear medicine and radioactive materials tightly secured.
8. Drill, drill, drill. This is a new threat and it must be prepared for in advance. Drills should be staged to test readiness, as with fires, tornadoes, abductions, and all other identified risks.

The law firm's advisory also emphasizes that the terrorism threat is not just an urban issue, noting that suburban and rural hospitals are just as vulnerable, if not more so, because of the limited backup and support hospitals immediately available.

Frew adds that one of his major concerns is the serious lack of background checks — not just arrest checks — that typifies hospital-hiring practices.

"I have personal concerns that hospitals are potential primary targets and not merely secondary targets," he continues. "Even disabling e-attacks on hospital computer systems can kill people. External attack is not the only means for terrorists to disable a hospital with devastating psychological effect."

"From the lowliest worker to the person claiming lofty credentials," he advises, "check out [potential hires] thoroughly."

ED liability

In another "e-bulletin" from his site, Frew reports on a recent court decision in which a hospital was held liable for the injuries incurred by a 15-month-old patient waiting for care in the emergency department (ED).

The hospital was held liable, he points out, "despite the fact that those injuries were caused by an unsupervised 5-year-old who was running amok while his mother was elsewhere in the ED."

The court stated, Frew adds, that merely warning the unruly child to behave was insufficient, and held that the hospital could be held liable for the injuries to the toddler. ■

NEWS BRIEFS

Laws hinder adoption of health IT, study says

Legal barriers posed by certain fraud and abuse, antitrust, federal income tax, intellectual property, malpractice, and state licensing laws hinder providers' adoption of health information technology, the Government Accountability Office (GAO) concluded in a recent report.

"Because the laws frequently do not address health information technology (IT) arrangements

directly, health care providers are uncertain about what would constitute violations of the laws or create a risk of litigation," the report says. Such "uncertainties and ambiguity in predicting legal consequences" make providers reluctant to invest significantly in IT.

The Physician Self-Referral or "Stark" Law and anti-kickback law, for example, make providers wary of establishing arrangements between providers that could promote adoption of health IT, the report continues.

GAO stated that, while the Department of Health and Human Services, which is charged with fostering broader adoption of health IT, has attempted to address some of those barriers, the agency's efforts have not been sufficient to overcome providers' concerns. The report is available at www.gao.gov ▼

CA bill sets minimum for hospital discount

The California legislature passed a bill (SB 379) in late August that would require hospitals in the state to provide financial assistance in the form of charity care or payment allowances to uninsured patients whose income is at or below 400% of the federal poverty level.

Gov. Arnold Schwarzenegger did not immediately indicate whether he would sign the legislation, which was opposed by two state health care agencies in the executive branch.

The California Healthcare Association (CHA) also opposed the legislation, noting that hospitals across the state already are addressing the issues on a voluntary basis.

In February, the CHA adopted voluntary guidelines for assisting low-income uninsured patients that recommend member hospitals provide financial assistance for patients at or below 300% of the federal poverty level. The guidelines also recommend hospitals limit expected payments from such patients to amounts received from Medicare and other government-sponsored health programs, do not garnish wages or place liens on primary residences to collect unpaid bills, and clearly post and communicate their financial assistance policies to patients. ▼

Hospital chain plans discounts for uninsured

Triad Hospitals plans to implement a new discount program for uninsured, self-pay patients at its 51 hospitals. The plans are subject to local restrictions.

Company officials said each hospital would offer a blanket discount of a certain magnitude based on its location, and that patients also would be able to apply for further discounts based on their financial means.

The Plano, TX-based company estimates that the new self-pay discount program will have no significant net impact on earnings per share, and said it will monitor and report on the financial impact of the program following implementation.

For more information, see the announcement at www.triadhospitals.com under "News." ▼

JCAHO panel to assist with cultural issues

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has appointed an expert panel to assist in a study of hospitals' efforts to address cultural and linguistic issues that affect patient care.

The 2½-year study will attempt to identify best practices for providing culturally and linguistically appropriate care in hospitals, and could play a role in future JCAHO accreditation standards. The study will involve site visits to a sample of 60 hospitals starting in May 2005.

The panel, which first met in July, will advise JCAHO in selecting hospitals for site visits,

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- Strategies for staff training
- Financial counseling initiative pays off
- The latest on HIPAA requirements

determining what information to collect, and developing a survey tool and protocol for collecting information.

For a list of panel members, see the press release at www.jcaho.org ▼

Moody's forecast dim for nonprofit providers

Nonprofit hospitals and health systems were given a dim forecast in a recent report from Moody's Investor Service, despite such positive developments as payment increases due to the Medicare Modernization Act.

The credit rating agency said the negative outlook is based on flat inpatient and outpatient volume growth; lower growth in reimbursement rates from both public and private payers; increasing expenses, particularly employee salaries and benefits; and looming capital needs.

Bad debt as a percentage of net patient revenue increased significantly, Moody's noted, attributing the increase to the shift of more health care costs to consumers through higher copayments and deductibles.

Though this year's median financial results are only "modestly negative" and "relatively comparable" with 2003 results, Moody's said it believes the median results are lagging indicators. ▼

HIPAA rule's effect on states explained

A new set of frequently asked questions (FAQ) posted by the Department of Health and Human Services Office for Civil Rights explains how the HIPAA privacy rule relates to state public records laws, also known as freedom of information laws.

According to the FAQ, the privacy rule permits a covered entity to use and disclose protected health information as required by other law, including state law. But when a state public records law permits but does not mandate the disclosure of protected health information, or when exceptions or other qualifications apply to exempt the protected health information from the state law's disclosure requirement, such disclosures may not be permissible under HIPAA.

For more information, go to www.hhs.gov/ocr/hipaa/ ■