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Six Sigma process greatly increases New Jersey ED's cash collections

Methodology is new to health care

A thriving emergency department (ED) cash collection program is the latest manifestation of Marlton, NJ-based Virtua Health's use of an innovative quality assurance and process improvement strategy called Six Sigma.

The ED project has been "wildly successful beyond our dreams," says **Kathleen Reilly-Santomero**, corporate director of patient business services/patient access for the health system, which includes four acute care hospitals and an ambulatory center that has an ED. Together, the five EDs see more than 125,000 patients annually.

The cash collection effort began in October 2003, and by June 2004, the five facilities had collected more than $452,000 just in managed care copays in a setting where previously there had been no cash collection at all, she says. **(See related story on ED cash collections, p. 124.)**

Another $280,000 in payment-due notices were distributed during the same period to patients who couldn't pay on the spot, Reilly-Santomero notes — roughly a quarter of which were returned with payment within 30 days. Within 60 days, about half were returned with payment, she adds.

Any patient who pays without being billed saves the hospital roughly $25 in billing costs, Reilly-Santomero points out, not to mention the percentage of the payment that goes to a vendor if collections are outsourced.

Virtua Health's embracing of the Six Sigma methodology came about as a result of the health system's partnership with GE Corp., she explains.

"We are in the process of building a brand-new, state-of-the-art hospital, which will be a GE showplace. It will have the latest GE equipment, from CAT scan units to PDA systems for physicians," Reilly-Santomero adds.

As part of that relationship, Virtua — one of the first five hospital systems to partner with the company — received management training that included Six Sigma, which has been described as a measure of quality that strives for near perfection, she notes.

A web site devoted to Six Sigma defines it as a "disciplined, data-driven approach and methodology for eliminating defects [driving toward six standard deviations between the mean and the nearest specification limit] in any process — from manufacturing to transactional and from product to service."

Although use of Six Sigma is more widespread in the manufacturing sector, it still is new to health care, Reilly-Santomero says.

"It is a system of measurements, where everything is measured and analytically controlled and contained. If you reach Six Sigma, you're perfect," she explains.

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Editorial Questions

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While Six Sigma has been used for years in industry to measure things such as "how many chocolate crunchies went into ice cream," its application to health care is somewhat on the cutting edge, Reilly-Santomero notes.

"We're using a manufacturing methodology in a human environment, so it has to be tweaked. We have to take into consideration the humanness of what we deal with," she says.

System's not 100% perfect

Those overseeing the cash collection project, for example, knew from the beginning that it couldn't reach perfection, Reilly-Santomero adds.

"It's an ED; we felt at least 50% [of patients] would be unable to pay for whatever reason, whether they had insurance or not, because they're not in a position to have money with them. "So scoping that 50% of patients would be our 'perfect,' we could only make 'three sigma,'" she explains. **(For more on the Six Sigma levels and training, see box, p. 125.)**

"Right off the bat, [the project] was an instantaneous success," Reilly-Santomero notes, adding that the outcome also held an interesting surprise.

Project leaders considered leaving the ambulatory center out of the cash collection initiative, she explains, because the majority of patients there were uninsured.

Interestingly, though, while not bringing in a lot of money to the project, that facility consistently has collected the most accurate amounts from those who do present with insurance.

With three sigma, this project's definition of perfect, the ambulatory center is at just under two sigma, a higher rating than that of the four Virtua hospitals, Reilly-Santomero says.

Part of the reason, she adds, is that the ambulatory center is a much smaller facility, where the registration area allows staff a better view of the patients than at the larger hospitals, which have four or five different exits from the ED.

'The success continues'

The significance of the Six Sigma project is that "the success continues," she points out. "It doesn't stop, [as] can happen with other projects."

The five phases that make up a Six Sigma project are referred to as DMAIC, Reilly-Santomero says, which stands for "define, measure, analyze, improve, control."

"We systematically work through those five

processes," she adds, "and it's the last phase — control — that keeps the project flowing with continual follow-through so that it doesn't fall short and disappear."

The in-depth analysis that often is lacking in other projects is done in advance with Six Sigma, Reilly-Santomero says.

"With the cash collection project, for example, we wanted to know how many copays we were collecting on the back end, and how many days it takes to [get payment] if we're not collecting," she adds.

"Then we measured all that data to find out what portion of that amount we could collect on the front end," Reilly-Santomero continues. "When we determined an appropriate number, we measured and analyzed and said we probably could collect only 50% of the total dollars on the front end."

Identifying the self-pay patients

When the cash collection program expands to include uninsured patients, she notes, project leaders will do an analysis to determine how many patients are genuinely self-pay customers, from whom the hospital actually collected revenue, at each campus.

Another organization looking at the issue of uninsured patients, Reilly-Santomero explains, has decided that instead of billing for every item, it would come up with a set amount, and if the patient could pay that, would write off the rest.

The idea is that the hospital "is not tracking [the patient] down to get every dime," she adds.

The advantage to the hospital is that billing and collection costs are eliminated, explains Reilly-Santomero.

Virtua likely will consider that and other approaches as it looks at expanding the cash collection effort, she says.

With a Six Sigma project, there are typically one or two sponsors — occasionally more — who set the parameters, she adds. "They say, 'This is what we would like to [have as] the bottom-line outcome.' With cash collection, for example, it was the chief financial officer.

"Who the sponsor is depends on what the project is," Reilly-Santomero points out. "It usually is a person who can make a decision even when it comes to spending money — the approvers of the final plan."

After a project is developed in a "work out" — an examination of how work can be taken out of a process — those involved report to the sponsors, answer questions, and literally get a wave of approval or a "whoa," she says. "It might be a 'whoa' because they wanted 10 full-time equivalents, and can only be given five."

Getting clinician buy-in

Key to the success of the cash collection project was gaining the cooperation of nurses and other clinical personnel, notes **Karen Foster**, manager of patient access management at Virtua Hospital, Voorhees campus.

"We had to come up with a process for identifying patients who need to make a cash payment, so we decided to have registrars mark those charts with a red stamp," she explains.

The charts are stamped after the patient is triaged, and then a card with managed care information is presented to a registrar, Foster adds, although no mention of payment is made at that time.

Because the registration area is isolated from the triage area and waiting room, it was particularly important to get the buy-in of clinicians, she says.

After the patient goes to the treatment area and receives care, the nurse handling the discharge sees the red stamp and directs or escorts the patient back to the registration desk to make the copay, Foster adds.

Patients whose charts do not bear the red stamp exit from the treatment area and do not go back by registration, she notes.

Because only managed care patients are directed to the registration checkout window, Reilly-Santomero points out, "the total volume isn't hitting a cashier space — only those who actually have copays."

"The physical layout is a big issue because [managed care] patients have to be registered, taken to the ED, and then returned to registration [for checkout]," Foster says. "It's a challenge because there are lots of exits."

"We are anticipating having decentralized registration within about three months," she adds, "which would put registrars, including a checkout person, right in the ED."

The department already does a great deal of bedside registration in the ED, but in moving a registration desk into the area "visibility to the patient would be greatly improved," Foster explains. "Where [registrars] sit now, they can't see the patient at all."

Although there was some initial reluctance on the clinical side to take a proactive role in the payment process, she says, cooperation came through convincing nurses that "it's not a clerical process; it's a team process that will benefit the entire hospital.

"You have to walk softly and carry a big stick," Foster notes. "Everyone is working in the Six Sigma project and understands that we needed to do [cash collection]. Once you have the right people in the room and the right buy-in, it trickles down to staff."

It helps that, at the Voorhees campus, the patient base typically has good insurance, she says. "These are generally people who pay their bills. Often in this environment, they're offering to pay."

Those who don't pay on the spot get the payment-due notice and have five days to send in payment before they are billed, Foster adds.

The project will be expanded over the next year to try to capture payment from self-pay patients, who now are billed after service, Reilly-Santomero says. "Those who need assistance will be directed to a financial counselor. That happens in phase two."

Patient throughput next up

The newest Six Sigma project on the access horizon has to do with patient throughput, she notes. In that work out, project leaders will look at "where we can take work out and consolidate the effort," Reilly-Santomero adds.

They also focus on the customer or customers involved, she says. "Sometimes, the customer is yourself. Sometimes, it's the physician. Sometimes, as with patient throughput, the customer is many people — physician, patient, clerical staff — so you analyze and get the voice of the customer."

That might involve bringing in small groups or doing a survey to get customer feedback Reilly-Santomero says.

As part of the work out, project leaders put the existing process on a big piece of paper on the wall, a process map that shows 150 steps involved in getting patients in and out the door, she notes. "We get the right people in the room — clinical folks, registrars, supervisory personnel for patient access, the nursing manager, the patient accounting and billing folks — and they look at the map to remove some of the work in the process."

With an initiative in the outpatient area, the goal is to speed the flow of scheduled patients so that they are coming in, having the service, and walking out the door, Reilly-Santomero says. "That may mean realigning staffing, and retraining. If so, we do that. We start with a clean slate."

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Six Sigma teams define, measure, and analyze

Barriers, opportunities identified

It's impossible to fully explain Marlton, NJ-based Virtua Health's emergency department (ED) cash collections project without discussing the multihospital health system's Six Sigma quality assurance program, officials there say.

Motivated by a recent Healthcare Advisory Board report touting the improved cash flow and customer service benefits of collecting revenue at the point of service, rather than through billing the patient later, the health system began the ED project in October 2003.

Using the methodologies of Six Sigma, the Virtua team worked to define, measure, analyze, improve, control (DMAIC) a new standard operating procedure (SOP) for ED cash collections, with the aim of increasing patient satisfaction and reducing costs.

Six Sigma teams are led by people who have attained the level of "black belt" or "green belt" or by Six Sigma analysts trained in statistical analysis, process improvement, and team facilitation. **(See box, p. 125, for information on advancement levels and training.)**

Tracy Carlino, RN, who is a black belt at Virtua Health, explains how the Six Sigma concepts were applied to the ED project:

- **Define**

To help define the cash collection process, staff members with firsthand experience in ED operations were selected for the Six Sigma project team, including representatives from patient access, patient accounting, information services, internal audit, and marketing and internal communications.

The team worked to identify barriers,

opportunities, and structural and process differences. To further define the task at hand, the team focused its efforts on managed care and managed Medicare copay collections.

The idea was to create an SOP that could be tested, implemented, and applied to other cash collection opportunities.

- **Measure**

Before a formal cash collections program was developed, the Six Sigma team measured data that indicated the system's collection agency was collecting approximately 50% of all potential copays from the ED at a cost of 5.2% of the total revenue.

The agency collected a net of slightly more than $1 million before the start of the project. The data also showed that the average copay was $50.

- **Analyze**

Through careful analysis, the team researched how other institutions were handling ED cash collections, both locally and nationally.

Additional research from the Health Care Advisory Board showed that hospitals collecting 80% of copays were deemed best practice. Those considered strong performers collected 60% of copays, and those collecting 50% of the copay opportunities were deemed average practice.

In addition to benchmarking information, the team sought legal advice to ensure compliance with the Emergency Medical Treatment and Labor Act (EMTALA) regulations regarding ED cash collections.

Analysis of the benchmarking information and the legal interpretation led the team to decide on a goal of collecting copays after treatment, with a first-year target of 50% of potential collections.

- **Improve**

Before the team could make recommendations for improvement, issues such as security, space, equipment, EMTALA considerations, staff education, and technology were addressed.

A cost analysis of the new design process was completed, with expenses including costs for minor renovations, credit card machines, safe and drop boxes, cash drawers, panic buttons, and security cameras for safety purposes, as well as signage for each ED.

Staffing changes were made within patient billing services to support the additional workload. Changes included moving the cashier to the ED and moving the auditor/educators to the registration area to help out during peak times.

- **Control**

A change acceleration process (CAP) is another part of the Six Sigma methodology that was put in place to encourage change early in the process, with actions including education plans, scripting for registrars, and public signage regarding the new collection procedure.

To promote continued success, the design team agreed to send progress reports to a broad audience of key stakeholders, including senior management.

The reports — designed to reflect both cash collected and payment due notices generated through the computer system — were produced weekly during implementation but only sent monthly. ■

Six Sigma Advancement Levels and Training

✔ **Black Belt**
The term black belt, taken from the concepts of martial arts, describes an expertise level pertaining to Six Sigma. A black belt at Virtua is a person who has received extensive training in applying the Six Sigma methodology in the form of define, measure, analyze, improve, control (DMAIC) to improve processes across the system. This is a full-time position. A vice president or chief operating officer may work with a candidate, or individuals may apply to enter the pool of black belts. The black belt internship is meant to develop high-performing individuals and, after two years, when they have gained experience and a much greater skill set, absorb them back into the organization.

✔ **Green Belt**
A green belt is a person who remains in his or her existing position with the organization but has the opportunity to learn how to use the tools of Six Sigma to improve the operation of that department or area.

✔ **Training**
The training, which is broken down into the steps of the DMAIC process, takes about 15 days and occurs over the course of a couple of months. It is done in phases that last two or three days. Black belts and green belts are trained on laptop computers, using programs such as Excel, PowerPoint, and Minitab.

Source: Virtua Health, Marlton, NJ.

'No right or wrong answer' on call center functions

Performance monitoring a necessity

(The discussion of call centers that began in the October Hospital Access Management *continues this month with some follow-up questions — posed by* ***Gillian Cappiello****, CHAM, senior director of access services and chief privacy officer for Swedish Covenant Hospital in Chicago — on staff training, balancing call workload, and other issues.)*

Question: In regard to staff training, could you address the issue of cross-training or staff blending? Is it better to have all call center representatives trained in all functions, or can you successfully have "pods" of representatives with more specialized or focused areas of expertise within a call center?

Answer: "We have done both here during the past few years," says **Georgina Trunzo,** director of patient access services for the University of Pittsburgh Medical Center (UPMC). "We have pods, but everyone has a backup specialty as well. It has helped us to have specialists in certain areas, such as self-pay/commercial, but cross-training is critical, as vacancies, illness, and increased volumes occur."

The more full service the call center, the more diverse staff and organization of staff are required, notes **Mary Lou Anderson**, director, physician and guest relations, for University Hospitals of Cleveland (UHC).

"Considering a full-service call center that includes physician-directed referral, consumer referral, and hospital operator and physician answering service, there are two distinct staffing levels — clinical and nonclinical," she adds. "In this model, there are four workgroups with the potential of additional pods supporting referral services — scheduling pods for specific clinical areas based on volume."

There is sufficient diversity within this model that allows staff to be deployed at high peak times so they can assist with services when one area is short-staffed, Anderson says.

"For instance, the answering service staff has high volume during lunch hours and evenings, while hospital operators are at high volumes mornings through late afternoons. Both are 24-hour services and have staff within the same skill-based level. There is dedicated staff for each service and a cross-service group that can work in either area, depending on high and low peak times," she explains.

At orientation, UHC call center employees receive information about the overall goals and objectives of the organization and the call center, she explains, and are given clear definition of behaviors and standards that drive pay for performance.

"Training continues within each work group so that information is drilled down to the specific requirements, standards, and behavioral expectations," Anderson says. Training then moves to the front line, she adds, where mentors are assigned to new staff for on-the-job training and are available as a primary go-to person for a defined period of time.

John Woerly, RHIA, MSA, CHAM, senior manager with the consulting firm Capgemini, says he prefers a skills-based blending of the work, dependent upon the individual staff member's experience and learning abilities, and the complexity of the job function itself.

"There really is no right or wrong answer as to which job functions can and should be blended," he adds. "Many issues need to be considered, including the depth of the job function, volume of customer contacts, etc. Some job functions can be easily blended, while others may have such a level of sophistication and knowledge transfer that if they were blended, high performance would be difficult."

Certain jobs lend themselves to the pod concept, Woerly notes. "Financial clearance activities are a prime example. The functions preregistration, insurance eligibility/benefit verification, precertification/authorization, primary care provider referral, and financial education/counseling can be successfully combined, providing patients with a consistent financial intake contact."

Question: How have hospitals with call centers successfully incorporated inbound and outbound calls vs. inbound only? Our call center is predominantly inbound, with some outbound calls for follow-up (i.e., to preregister patients if we couldn't do it at the time of scheduling, to get a diagnosis, clarify a test, or get a referral).

Answer: Call metrics should be used to properly balance workloads of inbound and outbound

calling, says Woerly. "The worst possible service would be to advertise an incoming number and have no one to answer it, or to answer only after multiple ringing."

"Dependent upon call volume," he adds, "coverage may need to be assigned [to] either incoming or outgoing call management. With the proper call distribution systems, calls can be automatically routed based upon skill sets and call volume."

Advanced call center

An advanced call center allows patients to contact the center any time and any way that best meets their needs, Woerly points out, noting that web contact, e-mailing, and other modes of communication must be considered to meet customer requirements.

The UPMC call center handles both inbound and outbound calls, Trunzo says. "We have inbound calls from physician offices placing a reservation, for urgent precertification, from a patient returning our call, or from an insurance company returning our call."

Outbound calls, she adds, are to insurance companies regarding commercial insurance and worker's compensation issues, or to patients for clarification.

"For inbound calls," Trunzo says, "we have set up queues so that physician offices do not wait, but rather the call bounces to a reservationist. In addition, all verifiers have multiple lines before the call goes to [a recorded] message."

At UHC, according to Anderson, staff are expected to follow up with outbound calls to meet insurance/scheduling requirements for preregistration.

Another opportunity for outbound calls occurs when physicians or their office staff call or fax the physician-directed referral staff with clinical information to have a patient scheduled (to a specialist or for a diagnostic test), she adds.

"The clinical staff responding to these situations do the following: call the patient to obtain correct demographic and insurance information, obtain any and all required test results or physician notes, determine a preference for time or location, and schedule with the appropriate physician or diagnostic service," Anderson notes.

"A call or fax [is] also sent to the referring physician providing the patient appointment information," she explains. "This is a 'big win' on the part of the referring physician, especially by providing easy access for patient appointments."

An Internet site is another area where outbound contact is required, she notes.

If requests for referral or information are directed to the call center, Anderson adds, staff can respond by e-mail or telephone.

Question: From your experience, which services are people calling for most often?

Answer: "Our service is a predominantly physician-directed referral, and our primary contacts are the referring physicians, their office staff or their patients," says Anderson.

"As a result, our calls are requesting full-service patient appointment scheduling to any physician specialty and hospital-based diagnostic/clinical service, based on the needs of their patients," she adds.

"We respond to marketing initiatives based on the priorities of the organization," Anderson says. "Because our call center staff is knowledgeable about the organization, [they] can quickly respond to new initiatives, assist with multi-scheduling situations, and provide personalized services as needed. Our staff is involved with ongoing marketing programs in addition to one-time marketing initiatives."

No contact center is exactly like any other, Woerly emphasizes, with the type of calls coming in dependent on what the call center offers. That said, he suggests that many calls will center around:

- New patients finding a physician (physician referral)
- Care issues (disease management)
- Questions regarding appointments (scheduling)
- General information (hours of operation, location of facilities, visiting hours, call transfer to an inpatient, etc.)
- Questions around financial/insurance issues (financial clearance, financial counseling and/or customer service)

Question: What is the value of a new person calling for physician referral or to sign up for a community event? How are organizations faring as far as downstream revenue is concerned? What about other measures of financial impact?

Answer: The goal of any call center is to bring in new business by fulfilling the requests of a caller, notes Anderson. "If the caller is satisfied,

there is the option for that relationship to grow."

The first contact is the most critical and must be handled by knowledgeable staff with a high level of customer service, she continues.

"Once a relationship is established, there is the potential for continued interaction and referral to other services. The caller may also share his positive experience with others, resulting in new business for the organization."

Activity must be analyzed against the financials of the organization, which must define its rules, including definitions of new business contacts, Anderson says.

"There needs to be a time period established prior to the encounter that determines 'no activity since . . . ,'" she suggests. "For the population that meets your requirement, the next step would be to look forward from the date of service one year out and document all activity."

Financial analysis should be done annually and for each marketing initiative or source of referral, Anderson says. "Determine which programs meet your objectives: Are you creating image and/or driving business? Conduct quarterly reviews of initiatives to determine call volume and appointments scheduled."

"Don't be afraid to stop a program or change along the way if the results are not what you expected," she adds. "Always return to your objectives."

Anderson describes these specific financial benefits derived from the UHC call center:

- Contained referral to University Hospital and within the health system
- Increased patient appointments scheduled annually since 2000
- Increased referral to diagnostic areas
- 93% of UHC business physician-directed

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

In the past year, Trunzo notes, AR days have decreased by 14, from 56 days to 42 days. *(Editor's note: This figure was incorrectly stated in the October issue of* Hospital Access Management*.)*

Question: If the call center is to be the one resource for everything, how do you manage that database of resource information? If the caller asks, "Do you have a program that deals with weight management?" What resources does the call center representative have to know how to direct the call?

Answer: A relational database and management of that database are critical for success, Anderson advises. "It is important for staff to be able to respond quickly and with knowledge."

Information about marketing initiatives should be shared with the call center, she says, and the call center should also be involved in the planning of the marketing initiative. Once information has been identified, add it to the database.

At the University Hospitals' call center, Anderson explains, every contact is associated with a source that allows the organization to link calls and actions taken to sources of referral.

"Our database includes physicians and their associated organizations," she says. "This is absolutely necessary for physician referral — the ability to identify where business is coming from and why."

UHC has unique telephone numbers for physician referral and others for consumer referral, Anderson notes.

"Our consumer referral has general consumer lines [local and toll-free], as well as those specific to an ongoing marketing program. Successful identification for the source of a call is important whether it is identified from a defined phone line or from information obtained at the time of the call," she says.

Availability to access other applications depends on the needs of the staff to respond or the function of the call center, Anderson adds. "If scheduling patient appointments is important, then access to a scheduling application is important."

Anderson emphasizes that, if call center employees do not know the answer to a question or are not sure of the answer, it is OK for them to say that they do not know.

"It is better to say this than to give out wrong information," she adds. "Our staff will take the time to find the answer and return the call."

Most advanced call centers have sophisticated customer relations management support, Woerly notes. "Keeping data and staff current on new programs, changing conditions and operational issues is essential."

Although it may be possible to run a successful call center manually, he adds, as functional layers are built and operations increase, it will become

increasingly difficult to maintain quality performance without investing in technology.

"Knowing what technology is required is the fine science," Woerly points out. "Additionally, having strong management in place with strong telephone knowledge is essential. Performance monitoring is a must."

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Labs don't need MSP information

CMS clarifies regulation

Hospitals no longer are required to collect Medicare Secondary Payer (MSP) information where there is no face-to-face encounter with a beneficiary, thanks to a recent clarification by the Centers for Medicare & Medicaid Services (CMS).

The change, which was effective Aug. 16, 2004, is because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

Section 943

Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) states:

"[T]he secretary shall not require a hospital [including a critical access hospital] to ask questions [or obtain information] relating to the application of section 1862(b) of the Social Security Act [relating to Medicare Secondary Payer provisions] in the case of reference laboratory services described in subsection (b), if the secretary does not impose such requirement in the case of such services furnished by an independent laboratory."

Before the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services.

The change brings relief to access managers who have long complained about the impracticality of complying with the requirement.

Sean Campbell, director of patient financial services at South Coast Hospital in Laguna Beach, CA, says the change has made the intake process and billing for specimens much easier for his facility.

"We receive a lot of specimens," he adds. The physician community was not forthcoming in terms of sending over information on whether Medicare was the primary payer, Campbell notes.

"Since the lab would come and we didn't have the physician to ask, we had to contact the patient after the fact [to ask the MSP questions]," he says. The step delayed billing, Campbell says, and required staff to make a call that otherwise would not be necessary, since they were sent other patient information.

"Just eliminating that [requirement] has given us the ability to have a more efficient operation," he says. "We take the specimen, bill for the service, and don't have to worry about the compliance issue."

Repeated questions are frustrating

Other complaints centered on the continuous re-asking of MPS questions of beleaguered patients whose answers had no chance of varying, as with nursing home residents who routinely have reference labs sent to a hospital to monitor a particular condition.

One *Hospital Access Management* reader told of having to repeatedly ask such elderly patients — or their family members — whether they had ever had black lung disease, currently had Veterans Administration insurance, or were involved with a government project that would pay the claim, despite their being long-term nursing home residents who obviously were entitled to Medicare coverage.

On the other hand, some access managers were concerned that a relaxation in 2002 of the frequency with which the MSP questionnaire must be signed for reference laboratory accounts could put hospitals at risk of inadvertent violations.

"We don't have a mechanism to know when the 90 days have expired and that the services the patient is receiving for the current visit apply to the MPS questionnaire on file," one reader pointed out in a July 2002 Access Feedback column. ■

NEWS BRIEFS

Success factors noted for ED patient flow

Eight common factors were identified as critical for success in improving patient flow in the nation's emergency departments (ED) in a report from the Urgent Matters Learning Network, a national initiative of the Robert Wood Johnson Foundation.

Ten hospitals were selected to participate in the initiative to help hospitals eliminate ED crowding and communities understand the challenges facing the health care safety net.

Practical management tools developed

The Urgent Matters team developed a series of practical management tools to address issues related to ED overcrowding.

However, as the initiative evolved, hospitals participating in the Learning Network developed a variety of strategies designed to improve patient flow and reduce ED crowding and, in the process, created their own best practices.

The report, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, lists these critical success factors:

- Recognizing that ED crowding is a hospitalwide problem, not an ED problem.
- Building multidisciplinary, hospitalwide teams to oversee and implement change.
- Determining the presence of a champion, an individual in a well-respected position who sells patient flow improvement to the medical staff and executive management.
- Guaranteeing management's support.
- Using formal improvement methods.
- Committing to rigorous metrics. (Data collection is an absolute requirement, the report says.)
- Making transparency an organizational value. (Sharing outcomes and results with all involved staff builds ownership and accountability, the report says.)
- Finding the right balance between collaboration and competition. ▼

Proposed rule targets improper payments

States would be required to estimate improper payments to health care providers and insurers for Medicaid and State Children's Health Insurance Programs under a proposed rule published by the Centers for Medicare & Medicaid Services (CMS).

Also under the proposed rule, the state would have to identify "emerging vulnerabilities" that could be addressed to reduce such payments.

CMS said the estimates are needed to meet federal requirements to estimate improper payments in the programs because the programs are administered by state agencies according to each state's unique program characteristics.

The rule — which can be found at www.access.gpo.gov — proposes requirements for producing the annual estimates and reporting them to the Department of Health and Human Services, which would use them to produce a national estimate. ▼

JCAHO hikes fees for hospital surveys

Hospitals will be charged about 10% more in fees for their triennial survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), beginning in January 2005.

On average, hospitals will see a $2,700 increase in survey fees, and those with 200 beds or more will be assessed an additional $3,500 for a new surveyor — a health care engineer who will evaluate compliance with Life Safety Code and physical plant requirements..

Increases for other health care organizations range from 5% ($300) for critical access hospitals to 20% ($3,000) for health networks. JCAHO last raised its fees in 2000.

The organization said it plans to allow accredited organizations to begin spreading their survey fees over the three-year accreditation cycle, starting in 2006.

For more information, go to the organization's web site at www.jcaho.org ▼

HMO profits soar from 2002 to 2003

The nation's HMOs nearly doubled their profits during 2003 to $10.2 billion, an 86% increase from the $5.5 billion reported in 2002, according to an analysis by Weirs Ratings Inc.

The company, which rates the financial strength of insurers, reviewed year-end data from 502 HMOs.

"The industry's soaring profits continue to irk both consumers and businesses who are shouldering skyrocketing health care costs without any perceived improvement in benefits," noted Weirs vice president **Melissa Gannon**, who said the next wave of consumer backlash may force HMOs to evolve their cost structures. ▼

Almost all hospitals to get payment update

Nearly every eligible acute care hospital in the country has successfully shared data on the quality of care it provides and will receive a full Medicare payment update of 3.3% next year, the Centers for Medicare & Medicaid Services (CMS) has announced.

Of 3,906 eligible hospitals, 3,839 (98.3%) met all of the CMS requirements and will receive the full annual payment update in fiscal year 2005. The remaining 67 hospitals chose not to submit the data. ▼

Panel will certify electronic records

A panel appointed to certify electronic health records designed for use in the outpatient setting will have initial certification requirements and processes ready for testing by summer 2005.

The Certification Commission for Healthcare Information Technology was appointed by the American Health Information Management Association, Healthcare Information and Management Systems Society and National Alliance for Health Information Technology to help ensure interoperability of health care information technology products with emerging local and national health information infrastructures. For more information, go to www.himss.org ▼

Reward efficiency from providers, report suggests

To slow health care cost increases, public and private health plans need to reward health care

COMING IN FUTURE MONTHS

- AMs share hurricane preparedness strategies
- Financial counseling initiative pays off
- The latest on HIPAA requirements
- Hospital chain works on turnaround
- Strategies for staff training

providers for quality and efficiency and better manage care for patients with costly conditions, according to a recent report by Commonwealth Fund president and economist **Karen Davis**.

Consumer-directed plans, which are generally a high-deductible health plan combined with a health reimbursement account, are not likely to curb costs and could worsen health outcomes by reducing needed preventive care and care for chronic conditions, the report says.

The report points out that 10% of patients account for 69% of health care costs. More information is available at www.cmwf.org ■

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2004 SALARY SURVEY RESULTS

Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
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Outsourcing, consulting opportunities on tap for well-prepared AM professionals

Technology, revenue cycle skills most valuable

Increases in outsourcing, the merging of health care organizations, and changes in the consulting business may equal some new opportunities for qualified access management professionals.

Skills that will be most in demand, several health care job placement specialists indicate, include a firm grasp of technology and a sophisticated understanding of the entire revenue cycle. There continues to be a large demand as well for people with medical records experience, and for a broadening of financial skills across the board.

Continuing education, meanwhile, is more crucial than ever, suggests **Colleen Campbell**, a recruiter for an executive-retained search firm based in Mission Viejo, CA, that specializes in the health care industry. "Wherever we're doing the recruiting, the emphasis is on good education."

"As candidates continue to move up and look for other opportunities, we've noticed that the pedigree or education is something that senior teams are focused on more than in the past," Campbell says. "The requirements have gone up because those who are concerned with finance have to be at the top of their game."

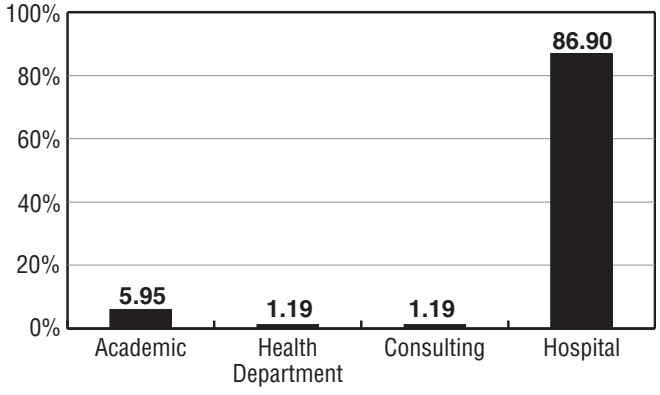
The candidate pool is getting stronger, she says, as the next generation of candidates tends to get advanced degrees or certifications earlier in their careers.

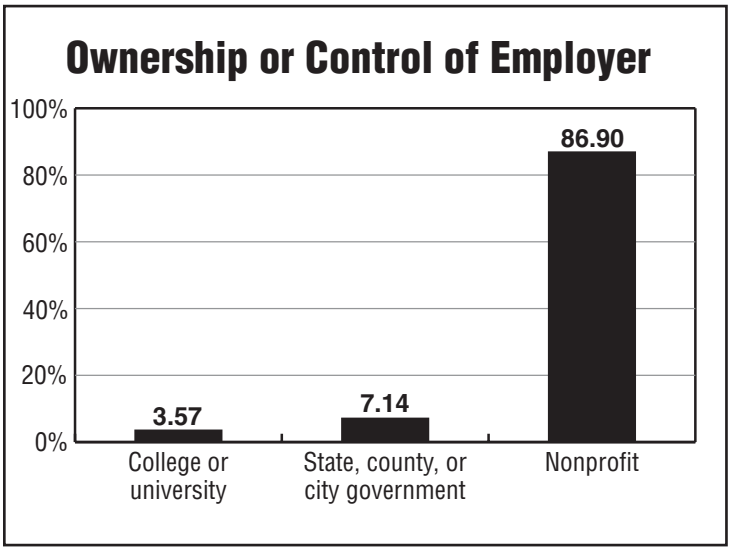
The ideal candidate will have career stability as well as a good education track, Campbell adds, staying long enough at a position to have demonstrable achievements.

Noting that salaries tend to be higher in California, she says a director of patient financial services at "a decent-sized hospital" might expect to make somewhere between $100,000 and $120,000, with the figure climbing closer to $130,000 if the person has regional oversight.

Increasingly, Campbell notes, individuals at the director level will need a broad knowledge of financial systems. "They [must] have that because they are hands-on and accountable. I don't think a

What is Your Work Environment?





person can be in that role today without a good grasp of technology. It's just the wave of the future."

The managed care industry is contributing to the demand for more well-rounded candidates, says **Chris Cornwall,** president and CEO of Searchlight Recruiters Inc. in Laguna Hills, CA.

"As managed care increases in the United States and we see a compression in reimbursement," Cornwall says, "a lot more hospitals have merged and aligned forces with organizations that might have been direct competitors in the past."

With this trend, "new jobs are being created, but other jobs are going by the wayside," he adds. "Because of the consolidation of the business force, more hospitals are looking for more sophisticated, experienced [employees]."

To fill this need, Cornwall says, hospitals are drawing on "a lot of people who have come up from different parts of the revenue management cycle — people who have come up from patient access, as well as from patient accounting, to higher and higher levels."

"Hospitals are using technology more and more to get a better grip on costs and to increase collections, among other things," he says. "I see technology playing a greater role, particularly software applications that are able to capture more of the earned revenue within a hospital. So we're seeing a need for people who understand and have been trained on these systems."

Another trend he has noticed, Cornwall points out, is an increase in outsourcing. Some of the large outsourcing firms are able to provide greater expertise than is available at small hospitals, he notes, and even larger hospitals may find outsourcing beneficial because the outside firms are more efficient at certain functions.

The changes taking place in the consulting business may provide opportunities for access management professionals with solid revenue cycle experience, suggests **David Borel**, managing partner for health care at the Atlanta-based firm of PeopleSearch Solutions.

Smaller, spin-off companies created from the leadership of the "Big Four" service firms "are beefing up right now," he reports. "They're using their past relationships to bid on deals and are offering better pricing points than the Big Four."

As a result, these firms are "frantically looking for qualified resources, for any kind of revenue cycle management [expertise]," Borel adds. "For someone coming from a hospital environment wanting to get into consulting, there are a lot of opportunities there."

Candidates for those opportunities will be made more attractive by experience in medical records, patient accounting, and patient financial services, Borel says, as well as by "an understanding of the whole ancillary [operation] — even from the clinical side."

He agrees that individuals "with hands-on exposure to technology will present themselves a lot better in the marketplace. It's more and more a part of anything you do."

In some cases, a consulting organization will be hired by a hospital and will need to put in, for example, an interim patient financial services director, Borel notes. "I will find someone to do it on a contractual basis for six to nine months."

Such internal consultant positions can be "quite lucrative" at present, he points out. "It can be feast or famine. Right now it's feast. It wouldn't be as big of a trend if business wasn't good."

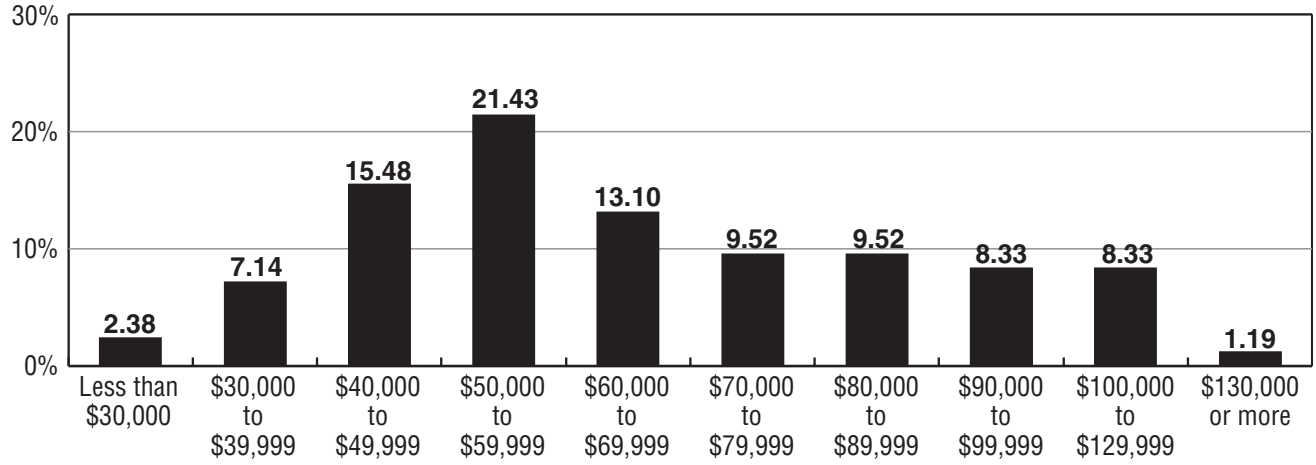
A client he recently placed had worked as a senior manager for a consulting firm, was a financial director for a health care organization before that, and had spent seven years as a revenue cycle consultant, Borel says.

That individual, who has an MBA in finance, is now interim patient financial specialist at a hospital, being paid about $800 a day, which, annualized, is $208,000, he adds. The same person placed in another consulting organization could expect to be paid between $140,000 and $150,000; and if hired for a full-time position at a hospital, would make between $105,000 and $120,000, Borel says.

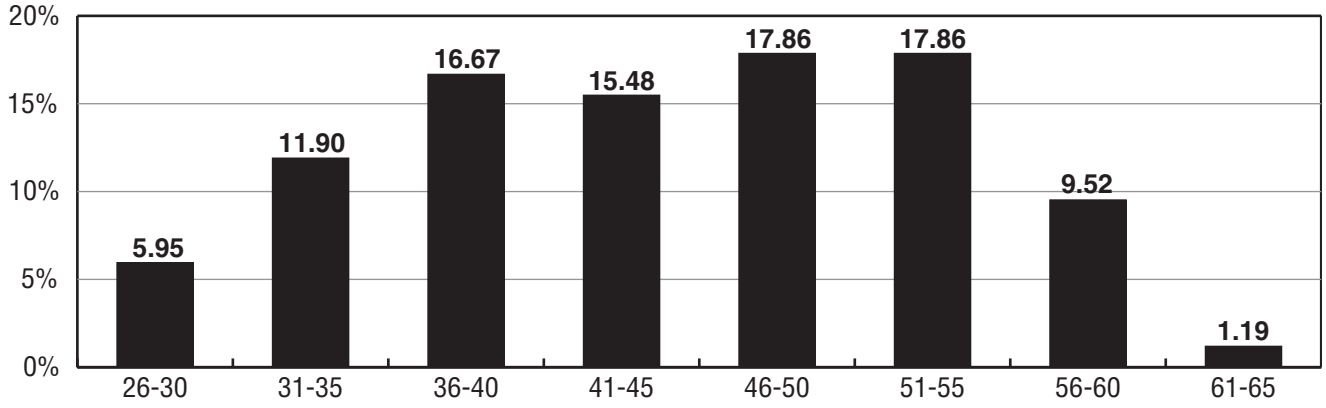
"It depends on the region of the country," he notes, "but there are two premiums — one for the travel, and one because you're an independent and don't have benefits."

(Continued on page 4)

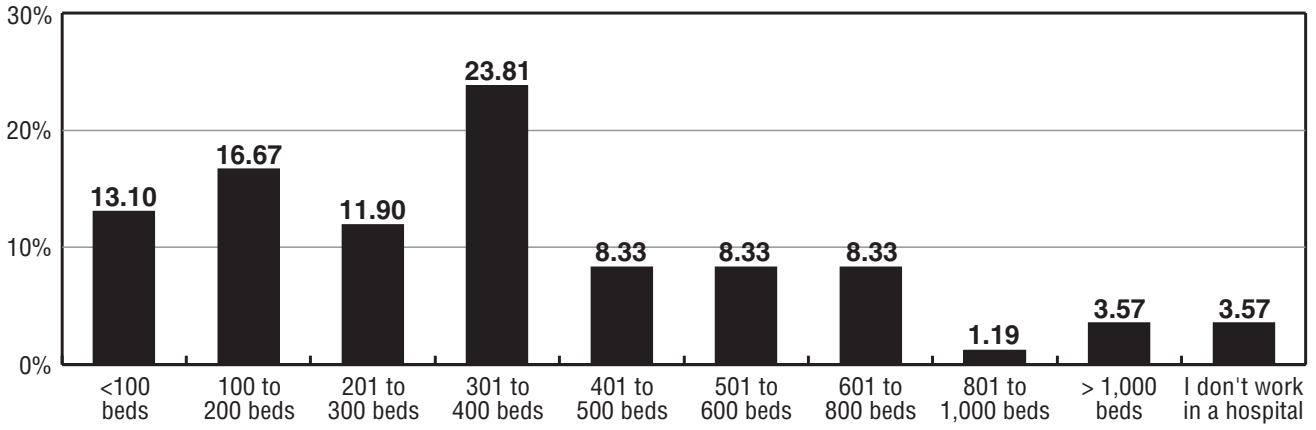
What is Your Annual Gross Income from Your Primary Position?



What is Your Age?



If You Work in a Hospital, What is Its Size?



Borel says he also has noticed a trend away from people placing salary at the top when they weigh job opportunities.

"Compensation overall has come down from where it was three to five years ago, when it was on the forefront of people making changes," he adds. "Now it's in the top three or four [priorities], but it's not one or two."

What's more important for today's job seekers, Borel says, are such considerations as "who you're working for, whether there's travel, or where the position will take you with a particular company. Just to get $5,000 more isn't a reason to select one job over another."

Those who are looking to make a career move can take encouragement from what appears to be a "good, forward movement" in health care employment, notes Campbell. "The last year to year-and-a-half, compared to about a year before that, the job market has picked up. [Organizations] are hiring again at the senior to executive level."

Given the aging population, adds Cornwall, there will be continuing demand for jobs that can help control health care costs. "The jobs where employees can add marginal value toward helping conserve the health care dollar — those are the jobs that will be growing in the future."

Salary breakdown

The greatest percentage of access professionals responding to *Hospital Access Management's* 2004 salary survey — 21.43% — reported making between $50,000 and $60,000 a year. The next largest category — 15.48% — included those with salaries of between $40,000 and $50,000, while 13.10% said their annual income is between $60,000 and $70,000.

Just more than 9.5% reported paychecks of between $70,000 and $80,000, and the same number said their salary was between $80,000 and $90,000. At the higher end of the pay scale, 8.33% reported incomes of between $90,000 and $100,000, and the same number said they make between $100,000 and $130,000.

Of four choices for job title listed in the survey, the most commonly selected was "director, access management" (32%), but almost 30% checked "other" in that category and a number of those wrote in such titles as "corporate director," "regional director" or "regional manager" of access management. Another 30% selected "access manager" from the choices given.

The vast majority (87%) worked for nonprofit hospitals, while the remainder said the ownership or control of their employer was best described as state, county, or city government, or a college or university.

A third of this year's respondents were affiliated with hospitals in the Midwest, while the next largest number (28.57%) worked in the South; 19.05% in the Northeast; 14.29% on the West Coast; and only 4.76% in the West.

When it came to the type of location, however, their facilities were divided almost evenly between urban, suburban, medium-sized city, and rural settings.

The overwhelming majority of respondents – just under 80% — got a pay raise in the past year, with most of those increases falling in either the 1% to 3% range (36.90%) or the 4% to 6% range (30.95%). Just fewer than 12% received an increase in salary of between 7% and 10%.

The gender gap in access management, meanwhile, was a bit less dramatic in this year's report: About 76% of respondents were female, compared to 85% in 2003. ■

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

How to implement HIPAA without breaking the bank

Lessons learned from one health care organization

Thinking creatively, but not expensively, is the key to meeting HIPAA requirements with a limited budget, according to **Maria Woods**, vice president for compliance and regulatory affairs at Saint Vincent Catholic Medical Centers (SVCMC) of New York, who spoke at the Ninth Annual HIPAA Summit in September.

Woods said her organization includes eight hospitals, four nursing homes, and home care, hospice, and other units. Implementing HIPAA across such an array of facilities required a core team of two people from the compliance department and two from information systems. Overall coordination of the effort came from joint compliance/information systems leadership, joined by regionally based individuals who were responsible for helping to coordinate awareness, education, data collection, and compliance in the individual remote facilities.

"HIPAA awareness and compliance needed to be integrated into the SVCMC culture so that it became a way of life," Woods said.

SVCMC's first HIPAA presentation came in December 2000, and the internal organization got its first dedicated budget in the 2003 calendar year. For privacy implementation, she reported, it was important to "triage the patient," determining what needed to be corrected immediately. Important steps included HIPAA awareness, electronic data interchange (EDI), authorization, business associates, policies, and notice of privacy practices.

"Make friends with information systems," Woods told attendees. "Set realistic goals and deadlines, and be honest about your own weaknesses. Review the HIPAA schedule and determine what you can realistically achieve."

Those responsible for HIPAA implementation need to become HIPAA experts, she said, by reading as much about the subject as possible, joining a support group ("misery loves company"), getting involved in Joint Commission activities, bringing in others from within the organization with specialized skills, and determining if outside help is needed.

"The best way to increase HIPAA awareness is to make privacy everyone's responsibility," according to Woods. "Use free labor in your organization. Find out who is already working in things involving privacy."

To put its privacy gap analysis on a fast track, SVCMC made directors and managers responsible for privacy and security questionnaires without a formal interview process and gave the HIPAA office responsibility for drafting needed policies. By April 2003, policies had been established, on-line training for essential personnel was complete, EDI testing had begun, and HIPAA forms such as authorizations had been completed, translated, and implemented.

When the October 2003 deadline hit, all SVCMC personnel had been HIPAA trained, the system was EDI compliant, old policies had been pulled or re-drafted, the business associates process had been completed, and the system privacy office was fully functional.

Moving on to compliance with security requirements, Woods said it is important to "stay focused on the issues and not on the new [technology] toys." Rather than just plugging gaps, she said, facilities should use security goals of confidentiality, integrity, and availability as guides to stay focused.

With a healthy dose of group therapy for all involved, Woods said, SVCMC's security approach involved leadership support, evaluating what was already available and identifying needs and possible threats, evaluating the system's score, fixing problems that were found, reevaluating the risk,

documenting everything, and staying alert.

"Privacy and security can tag team," she said. "Couple your risk analysis with your privacy monitoring and look at instances where security initiatives impact privacy."

Woods listed seven rules for those working on HIPAA implementation on a tight budget: 1) money for education is never wasted; 2) use consultant cash wisely; 3) there is only one captain of any ship, but every captain needs a crew; 4) KISS (keep it simple, stupid); 5) change is good, change is your friend; 6) don't be afraid to show what you don't know; and 7) play nicely with others. ■

Medicare to make greater use of the Internet

Data on non-HIPAA-compliant claims captured

Medicare continues to work closely with contractors, providers, billing agents, clearinghouses, and software vendors to achieve HIPAA goals and will be making greater use of the Internet and working on implementation of electronic attachments to electronic medical records. That's the assessment of **Gary Kavanagh** from the Centers for Medicare & Medicaid Services' (CMS) Office of Information Services at the Ninth Annual HIPAA Summit in September.

As of the week of Aug. 2-6, 2004, he said, 96.74% of all electronic claims were in HIPAA format, 98.3% of claims processed by intermediaries were in HIPAA format, and 96.34% of claims processed by carriers were in HIPAA format. There are 63,160 current electronic receivers, he said, with 48% of them (30,551) in production on HIPAA.

CMS is consolidating the claims crossover process, known as the Coordination of Benefits Agreement (COBA) initiative, according to Kavanagh. A small number of trading partners are beta testing the process through Oct. 24. If the test is successful, it will move into full production status, with all remaining trading partners transitioning to the national COBA process during FY 2005.

Beginning last July, CMS started capturing additional data on non-HIPAA-compliant electronic claims, reported Kavanagh. The data are state-specific and are broken out by provider type. They will be used to support outreach efforts and any decision to end the Medicare electronic claims contingency plan.

Compliance with submission of claims in HIPAA format improved considerably, he said, once CMS announced that effective July 1, 2004, noncompliant electronic claims would be paid after 27 days, the same as paper claims.

Kavanagh also discussed CR 3031, which was published for implementation in July and conforms Medicare billing requirements to the data content and format requirements in HIPAA, affecting only institutional providers. He said CMS made the changes outlined in CR 3031 to facilitate coordination of benefits transactions (500 million Medicare claims crossing over to third-party payers) that would have been rejected. ■

HIPAA enforcement aimed at achieving compliance

Most complaints about claims payment

Centers for Medicare & Medicaid Services (CMS) Office of HIPAA Standards staffer **Dianne Faup** says the agency has received more than 200 transaction/code set complaints, with some 58 still open at the time of her September presentation to the Ninth Annual HIPAA Summit.

Most of the complaints have been about claims payment, often pitting small providers against health plans and clearinghouses over adverse impacts on cash flow, she said. To date, five corrective action plans have been submitted. CMS enforcement continues to be complaint-driven and focused on securing compliance.

Medicare compliance rate above 80%

Faup reported that many covered entities continue to operate under contingency plans, although many are moving into compliance, with the Medicare compliance rate at more than 80% for claims. Reasons given for noncompliance include new data elements, reliance on vendors, and delays in starting implementation, she said.

The end of contingency plans is coming, Faup cautioned, and payments may stop if entities are not compliant. She also said there is a need to embrace other transactions, such as automated eligibility, remittance, and claims status, and a need to participate in the standards revision process.

Even at this juncture, Faup said, some positive impacts can be seen, including the realization

that HIPAA standards have an impact on business processes, the industry is coming together to work on implementation, and different provider groups are coming forward to participate in the standards.

She told Summit attendees their organizations should be following the HIPAA rules to achieve compliance, keeping aware of future HIPAA standards rules, and participating in industry organizations so their voice is heard. Coming next, she said, are the security requirements and the national provider identifier (NPI).

The security requirements, which take effect April 21, 2005, for all covered entities except small health plans and April 21, 2006, for small health plans, require organizations to ensure confidentiality (only the right people see information), integrity (information is what it was supposed to be and hasn't been changed), and availability (the right people can see information when needed). The security requirements apply to electronic protected health information that a covered entity creates, receives, maintains, or transmits.

Organizations must: 1) protect against reasonably anticipated threats or hazards to the security or integrity of information; 2) protect against reasonably anticipated uses and disclosures not permitted by privacy rules; and 3) ensure compliance by their work force.

In developing their plans, covered entities can consider size, complexity, capabilities, technical infrastructure, the cost of procedures to comply, and potential security risks, according to Faup.

For the NPI, the final rule was published Jan. 23, and the effective date is May 23, 2005. By May 23, 2007, for all covered entities except small health plans and one year later for the small health plans, covered entities must use NPIs to identify providers in standard transactions. ■

Security rule guidance issued to covered entities

Entities covered under the HIPAA security rule are not required to certify compliance with provisions of the rule, according to guidance issued by the Centers for Medicare & Medicaid Services. The security rule does, however, require covered entities to periodically perform evaluations to establish the extent to which technological and nontechnological security policies and procedures meet the requirements, the agency says.

"The evaluation can be performed internally by the covered entity," the guidance says. "There are also external organizations that provide evaluations or certification services. A covered entity may make the business decision to have an external organization perform these types of services. It is important to note that the Department of Health and Human Services does not endorse or otherwise recognize private organizations' certifications, and such certifications do not absolve covered entities of their legal obligations under the security rule. Moreover, performance of a certification by an external organization does not preclude HHS [the Department of Health and Human Services] from subsequently finding a security violation."

Guidances also have been published on other areas of the security rule, addressing questions such as the difference between risk analysis and risk management, whether access control requirements cover remote employees (they do), and whether minimum operating system requirements are mandated for personal computers (not always).

(Check the guidances on the Frequently Asked Questions page of the Centers' HIPAA administrative simplification web site at www.cms.hhs.gov/hipaa/hipaa2.) ■

Journalists complain about HIPAA privacy restrictions

The Radio-Television News Directors Association (RTNDA) says all journalists, and particularly those working for electronic media, have been hampered in their work by actual HIPAA privacy requirements and by interpretations of those requirements by some people and organizations.

In testimony before the National Committee on Vital and Health Statistics, RTNDA president **Barbara Cochran** said HIPAA as written and interpreted "is making it harder for electronic journalists to gather information and report on issues and events of local and national interest."

Cochran said the public's interest in health care information should not be underestimated.

"There is a public interest," she said, "in knowing whether victims of crime or disasters are being treated in the hospital and what their general status is. There is a public interest in knowing the health of our public officials and its relationship to how those officials carry out their

duties to the public. There is a public interest in uncovering corruption or mismanagement at the facilities where individuals receive medical care for themselves and their families. There is a public interest in learning about a wide range of health care issues that affect the community and being able to make informed decisions regarding those issues."

But, she said, unfortunately the HIPAA privacy rule was published without accommodation or even acknowledgement of journalists' concerns about how the rule would cripple their ability to tell stories. People are afraid that giving out information will expose them to litigation, penalties, or fines, Cochran added.

"Hospitals, emergency medical services, and some fire departments that operate ambulances are among the affected sources," according to Cochran. "And because of the confusion surrounding the privacy rule, sometimes police, firefighters, sheriff departments, and even football coaches believe they no longer can talk about a sick or injured person in public."

Through word of mouth or misinterpretation, she said, a widespread belief has developed that the HIPAA guidelines prohibit release of any information about an individual's medical condition or treatment by anyone if it is coupled with any information that can reasonably identify the individual. As a result, many noncovered entities, even including victims' relatives, believe they must protect information obtained from health care workers about a patient or victim they have obtained first hand. A more skeptical view of the situation, Cochran said, is that law enforcement and government officials may be using the law's privacy rule as an excuse to avoid disclosing information they simply wish to keep from the public eye.

'The public record is shrinking'

In addition to problems caused by erroneous interpretations of the requirements, Cochran said journalists also face problems arising from application of the rule as written and intended. "The rule itself removes from public view a significant amount of truthful information that is vital for the public to have in order to make intelligent decisions," she declared. "By prohibiting the dissemination and publication of any individually identifiable health information — regardless of the public interest in that information — the HIPAA privacy rule effectively has censored both daily news reports on basic hospital information about patients who are victims of violent crime, accidents, or natural disasters, and investigative reporting concerning health care fraud, patient abuse, or environmental hazards. . . . .Because of HIPAA, the public record is shrinking to include only sterile statistical reports and dry recitations of events stripped of the human element." ■

Guilty plea in first HIPAA privacy case

A SeaTac, WA, man pleaded guilty in federal court to wrongful disclosure of individually identifiable health information for economic gain. The guilty plea entered by Richard Gibson, 42, was the first criminal conviction under the HIPAA privacy rule, according to the U.S. Attorney in the Western District of Washington.

In a plea agreement, Gibson admitted that he obtained a cancer patient's name, date of birth, and Social Security number while he was employed at the Seattle Cancer Care Alliance and used that information to get four credit cards in the patient's name. Gibson used the cards to spend more than $9,000 in the patient's name, buying video games, home improvement supplies, apparel, jewelry, porcelain figures, groceries, and gasoline for his personal use. He was fired from the job shortly after the identity theft was discovered.

The plea agreement sets forth a sentencing range of 10-16 months in prison followed by a period of supervised release. ■

Civil money penalties rule extended

The Department of Health and Human Services extended for one year the Sept. 16, 2004, expiration date for an interim final rule establishing procedures for imposition of civil money penalties on entities that violate HIPAA administrative simplification standards. The agency said it needs more time to develop a more comprehensive enforcement rule, and the extension was needed to avoid the disruption of ongoing enforcement actions while development of the comprehensive rule is finalized. ■