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FEBRUARY 2005
VOL. 24, NO. 2 • (pages 13-24)

Challenges of Florida hurricanes bring out the best in HCA staff

Many heroes from these disasters

When a series of four hurricanes hit the coasts of Florida during August and September 2004, it was the worst of times and the best of times, says **Lois Holcomb**, regional patient access director for Hospital Corporation of America's (HCA's) Tampa region. **(See summary of hurricanes' activity and damage, p. 15.)**

The worst times had to do with evacuating critical care patients, determining how to register and bill patients moved from one facility to another, and anticipating the target of a storm that changed course at the last minute, she notes.

Fear kept some nurses from returning

In some cases, staff who had weathered one hurricane refused to come to work as hospitals prepared for the next one, Holcomb says. "The administration [at one Gulf Coast facility] said, 'We're evacuating patients, but we still need people to report to work'; and [staff] just said 'No.' They left because they were scared. The hospital couldn't get nurses to come in."

On the other hand, she points out, "I have so many heroes in this story. A situation like this sometimes brings out the best, which far outweighs the worst.

"We had nursing staff from a [Florida] east coast facility who got on a bus and came over to the [Gulf Coast] to assist after Charley hit because we couldn't get enough nurses," Holcomb adds.

"HCA made sure that folks who did not have a place to show up for work — or who couldn't show up because they had lost their home — still got paid. They put together a fund for the whole company to contribute to so that employees who were in need had money to take care of home issues," she notes.

Busloads of staff from the Tampa area went down the coast to Port Charlotte, which sustained a direct hit, to help employees put roofs on

their homes, Holcomb says.

"Our patient account services employees collected things that staff really needed down there, because the grocery stores were cleaned out and couldn't open because there was no electricity."

Holcomb rented a large SUV and took needed items to the patient access staff at the affected Port Charlotte facility — Fawcett Memorial Hospital.

"They would come in and pick out what they needed. And what was not needed, they would give to the rest of the hospital staff. I also made several trips [later] with carloads," she notes.

On one of those trips, she was accompanied by the patient account services (PAS) CEO and COO, Holcomb explains. "In addition, a truckload of items donated by the PAS staff was delivered to Fawcett by the HCA supply chain."

A change in direction

When Hurricane Charley hit, "we were prepared at the hospital level in terms of a disaster plan, but [not so much] in terms of what occurred during the hurricane," Holcomb notes.

Charley was expected to hit Tampa, but instead, the hospitals most affected were those in Port Charlotte, which took a direct hit, and Fort Myers, Holcomb says. As a result, the HCA facility in each of those cities had to be evacuated because of roof damage, she adds.

"As part of disaster planning," Holcomb notes, "patient access staff are prepared to assist in other areas because you don't expect people to come to the hospital during a hurricane.

"At Port Charlotte, although they were evacuating, people were not taking [the hurricane threat] seriously, since the storm was forecast to head north. Once they saw the storm was coming to them, people didn't know where to go and would show up at the hospital."

Prior to that influx, the hospital had been receiving special-needs patients — such as those who require oxygen, she notes.

"There are different levels of evacuation, and the first is for special-needs patients and those who live in mobile homes. After that, it's based on elevation [of homes]."

Emergency plans for pets, too

Because the storm jogged to the right at the last minute, the area had not been fully evacuated, Holcomb adds, and "people showed up at the hospital with family members and animals."

"Usually, facilities anticipate that staff will come to work knowing they may have to stay [for an indefinite time] and will bring family members with them," she says.

Normally, animals aren't allowed anywhere in the evacuation facility, Holcomb points out.

However, there is an increasing awareness on the part of those in charge of evacuations, she says, that people have animals, and they aren't going to leave their homes without them.

Fawcett Memorial, Holcomb notes, "did a dynamic job of being sensitive to that situation, particularly with the elderly."

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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

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

In fact, the hospital established a pet shelter that started in a supply closet and eventually was moved to an accounting area on the ground floor, says **Debbie Elliott**, patient access director at Fawcett. "We even had a snake."

During the influx of shelter seekers, Holcomb continues, patient access staff were responsible for identifying those who were walking in, putting their names on a list, noting where they were told to go in the hospital, and taking information on any skills they might have.

"Maybe someone was a retired nurse — we would want to know that," she says, adding that others might be needed as translators or to help transport patients.

Some of the arrivals were planned, as when physicians called and said they had special-needs patients who needed to come over, Holcomb says. "The nursing homes were emptying out."

Once the storm hit, and the roof and water problems began, patients were moved from upper to lower floors, she says. Eventually, all of the hospitals in Port Charlotte — including two non-HCA facilities — had to be evacuated, she adds. "HCA hospitals to the north, in Sarasota, Englewood, Bradenton, and even as far north as St. Petersburg, had to prepare to take those patients."

"It happened on Friday, so the critical care patients had to go out that night, and Saturday and Sunday the others were taken," Holcomb explains.

During this period, communication was problematic, with cell phones not working and limited systems availability, she notes. "HCA's main computer hub for Florida is in Orlando, and Charley went right through Orlando. This created periodic system outages."

Meanwhile, Holcomb says, "patient access staff were assisting with patient care to the degree that they could. The hospital had removed patients from the facility itself and had set up tents. So staff were comforting patients and trying to assist family members."

Fawcett Memorial was able to keep the emergency department open for limited services throughout and after the storm, she says; but if there were serious injuries, patients had to be put in an ambulance and sent elsewhere.

Getting access to patient data

From an operational standpoint, Holcomb points out, the optimum scenario for hospitals in shared environments, such as the HCA system, is when facilities have access to each another's

Summary of 2004 U.S. Hurricane Damage

Hurricane	Date hit U.S.	Impact
Charley	Aug. 13	Category 4 at U.S. landfall. Entered U.S. at Punta Gorda, FL, and neighboring Port Charlotte and traversed central Florida. U.S. Deaths: 10 direct, 20 indirect. U.S. Damage: $14 billion (second costliest hurricane in U.S. history).
Francis	Sept. 5	Category 2 at U.S. landfall. Entered U.S. at Hutchinson Island, FL, and moved west-northwestward across central Florida to the northeastern Gulf of Mexico. U.S. Deaths: 6. U.S. Damage: $2 billion to $6 billion.
Ivan	Sept. 16	Category 3 at U.S. landfall. Entered U.S. near Gulf Shores, AL, and moved northeastward emerging off the Delmarva Peninsula. U.S. Deaths: 26. U.S. Damage: $13 billion.
Jeanne	Sept. 26	Category 3 at U.S. landfall. Entered U.S. at east coast of Florida near Stuart, FL. U.S. Deaths: 5 (at least 3,000 indirect deaths in Haiti from inland flooding). U.S. Damage: $6.5 billion.

Source: Florida State University, Tallahassee. Web site: www.met.fsu.edu/explores/tropical.html.

database during an emergency situation.

She emphasizes the importance, however, of being extremely conscious of Health Insurance Portability and Accountability Act (HIPAA) privacy regulations if such access is granted.

At HCA, access to another facility's data is given sparingly, and only to a person at the director or supervisor level, Holcomb adds. "HIPAA requires that we only have the information we need to know."

Preregistration saved time

For example, at Doctors Hospital in Sarasota, which received patients that were being evacuated from Fawcett Memorial, the patient access director — after making the request to HCA's regional IS department — got limited access to Fawcett's database, she explains.

The director then accessed only the data on the patients Doctors Hospital was receiving and printed the demographic and insurance information for registrars, who prepared an account in the receiving hospital's system, Holcomb points out.

"When the patient arrived by ambulance and a room number was assigned, the registrar could simply activate the account, and they were ready to go," she says. "Nurses could start the ordering process."

In effect, those evacuated patients were preregistered to the receiving hospital just like any scheduled patient, Holcomb notes. "That was a huge advantage."

Conversely, in cases where a hospital receiving evacuated patients was not able to gain access to the patients' records, she adds, "we had to rely on the transferring facility to send us the information we would need. Sometimes, it came with the patient. Sometimes, we got very little."

Later, on the back end, access staff had to determine, for billing purposes, how to record the patient's status — whether inpatient, outpatient, or observation — Holcomb says, depending on whether the patients would go back to the original facility or stay at the one to which they had been evacuated.

"If patients return to the facility [from which] they were transferred, then that facility bills [the payer] for the entire stay; and the one where they were housed temporarily bills that facility," she explains.

That didn't happen during Charley, Holcomb adds, because Fawcett had to close. And even when it reopened, the facility could accommodate only a limited number of patients, so it didn't take back the evacuated patients.

Instead, staff placed all the accounts in observation status at the receiving facility, keeping them as outpatients until it could be determined how the billing should be done and then changed them to inpatients, she explains. "So there was a lot of cleanup."

Using hurricane experience to plan ahead

The experience with Charley better prepared the access staff for hurricanes Ivan, Jeanne, and Frances, Holcomb says.

"Before, we never even thought about billing issues on the back end [as part of hurricane preparedness]. You definitely need to be aware of the billing regulations — by payer — as to these disaster situations. "Typically, commercial payers follow the same billing standards as Medicare," she continues.

"We worked closely with our contracted managed care payers to address any specific issues. Managed care payers waived the 24-hour notice of admission requirement as a result of the hurricanes," Holcomb explains.

The Tampa HCA patient accounts service center handles 22 facilities in the state of Florida, and all are on the same system, Holcomb says, which allows the organization to more easily share staff — as well as patient data — throughout the different facilities.

Another PAS center in the state handles 19 facilities, she notes.

Staff helped out at their sister HCA facilities not only during the fallout from Hurricane Charley on the Gulf Coast, she points out, but also when the east coast was hit by Frances and Jeanne.

"Those hurricanes were so long that the employees there were exhausted," Holcomb says.

"After the storms were over, facilities that weren't hit as badly — including some in Miami and Fort Lauderdale — sent staff up to Port St. Lucie and some of the other hospitals that were hit harder," she adds.

After Charley, Holcomb adds, Holcomb sent staff from the Tampa area down to Port Charlotte. "It was the same system, so they already knew how to register patients."

Nurses were shipped all over the state as well, she says, including to the Panhandle area, which was hit by Hurricane Ivan. "Wherever the need

was, HCA was able to fill some of those needs from within its own organization."

After the hurricane, notes Elliott, a team for each hospital department sat down to evaluate the facility's handling of the crisis. She says there is little she would do differently, giving high marks to the administrative staff.

"Our CEO kept us informed constantly," Elliott says. "Beginning a week prior [to the hurricane] he kept us up to date on everything, and it was up to us to relay the information back to our staff."

A day-care center, staffed by patient access employees, "was probably the best thing we did," she adds. "We had to have nurses here, so we kept it up and running for about two weeks [to provide care for their children]."

Another thing that worked very well, Elliott continues, was the intake of shelter seekers, including the families of physicians, staff, and patients.

"We placed an armband on all of them and kept a running list of adults and a separate list of the children. Because we had the day-care center, we needed to make sure which child belonged with which parent."

The practice of listing people's skill sets came in handy, she notes, when one of the visitors started having chest pains. "We found the doctor real quick."

With both hurricanes — Charley, and in anticipation of Ivan — staff made copies of all the medical records, Elliott says.

"We set up a pool of employees who were here seeking shelter, and they did nothing but make copies of records. Any patients who were transferred out [took] a medical record went with them. That was also helpful [for] the receiving facility."

To keep a close eye on who was where in the hospital, she says, Elliott did a house census every 15 or 20 minutes prior to the first hurricane. "We would periodically go to each floor and make sure that Betty Jo was really in Room 204, Bed 1, as our report said."

One thing she wished she had been better prepared for, Elliott notes, was when the ED took a big hit that destroyed the doors.

"We had to evacuate and go to the second floor, and we weren't prepared to do that. We were scrambling to find printers, computers on wheels, etc."

In hindsight, she adds, "once we got confirmation the hurricane was coming close, we should have either evacuated [the emergency department] or started to get paperwork in place. We could have left a registrar downstairs until the last minute and taken some of the equipment upstairs."

Access staff served as runners, helping to fax and make copies of information being sent to other facilities, Elliott explains. "On the second floor, where we had a command center set up, I relied on my staff to go around and help keep people calm."

The day after the hurricane, access employees helped coordinate the arrival and departure of ambulances, she adds. "It was very chaotic. By 8 in the morning on Saturday, we had 36 ambulances lined up in our driveway.

"There was a person stationed at the door to greet them and confirm where they were going," Elliott continues. "We were in constant communication with case management and knew at all times which patient was going where."

Another lesson learned through experience was the importance of — if a facility is damaged and able to be open only in limited capacity — looking at the room and board master files to make sure they are set up appropriately in terms of charging for patient stays, she points out.

Because of the different price categories — rehab beds are charged at a different level than intensive care unit beds, for example — changes have to be made when the beds are used for a different type of patient, Elliott adds.

Balancing different needs

Holcomb says one of the most memorable aspects of the hurricane experience involved the human relations challenges.

"My patient access directors did a really good job of trying to balance the needs of their employees — being sensitive to what they were going through personally, while meeting the staffing needs of the facility," she notes.

"I had several directors who were there 24-hours a day until the fallout from the storm was under control. They never left the hospital."

While each CEO handled things a little differently, Holcomb adds, "the hospitals that really rallied were those that allowed families to come in and even bring their animals.

"That human touch goes a long way, and it isn't forgotten after the storm. Every time I go down to Fawcett, they're still saying thank-you," she recalls. "We all have a job to do and during a

disaster situation, that's first and foremost. But employees also have their needs and a family they're worried about.

"It's one thing to ride out a storm at the hospital, and another thing to then go home and see if you have a home," Holcomb concludes.

(Editor's note: Lois Holcomb can be reached by e-mail at Lois.Holcomb@HCAHealthcare.com.) ■

One-on-one education is key to Virtua success

Auditor/educators play big role

By implementing a comprehensive full circle of training for patient access employees — which ultimately led to the creation of two new areas within the department — Marlton, NJ-based Virtua Health has dramatically increased both registration accuracy and employee satisfaction, says **Diane Mastalski**, corporate multisite administrator for patient business services for the 1,051-bed system.

"In early 2000, we got a new assistant vice president [AVP] for patient business services, and his dream was to put together a training program for patient access and patient accounting, which are both under the same AVP," Mastalski explains.

The patient business services department includes 100-125 patient access employees, she adds, and 100 patient accounting employees.

An additional 150 employees who do not report to patient access perform registrations in the five-hospital system's ancillary areas and at one of the hospital's emergency departments, Mastalski notes, and are included in access education initiatives.

The new AVP's vision led to the establishment of a training and development department for patient business services that has a manager, a supervisor (Mastalski's job at the time), two access trainers, and two accounting trainers, she adds. "We realigned staff; we didn't outlay any money."

In the process of establishing the new department, Mastalski points out, "we met with our organizational effectiveness people who do systems training, inservices, and training seminars. We looked at what we were doing right and what we needed to do better."

About 10 years ago, there was no formal training for registrars at all, she recounts. New hires learned from a person who already was in the job, "so if I [was taught by] Mary, I learned one thing, and another person [who was taught by] Jane learned differently."

With the implementation of a new computer system in 1994, three days of classroom training was added to the mix, but that time was spent primarily on computer training, Mastalski adds.

Training targets new and current staff

The initiative that began in 2000, however, has a comprehensive training agenda that targets new and existing employees and covers a wide range of registration topics.

In 2003, Virtua upgraded its health information systems (HIS) program and, at the same time, increased the initial training session from three days to four, primarily to allow more time for insurance education, Mastalski notes.

The insurance piece of the training is now much more detailed, she says, with instruction on how to read each payer's insurance card and identify plan code, billing address, etc.

"In the past, it was much more general," adds Mastalski. "We might get specific with Medicare and one other [insurer]. Now we're breaking it down, saying, 'Aetna has this; Blue Cross Blue Shield has this.' It's more geared toward the individual plan."

In the four days of training, she adds, registrars also cover such topics as "how to post cash, scripting, patient consents, HIPAA [Health Insurance Portability and Accountability Act] information," among others, along with "any special requests that come in." Because trainers have become more efficient in presenting information, there's still enough time for the computer training, Mastalski says.

"Plus, our new HIS system is easier than the previous version, so we can cover that more quickly and give them more meat and potatoes," she notes.

One of the things Mastalski finds particularly effective about the four days of training, she explains, is that they are scheduled with insurance information as the last session of one day, and instruction on the Healthcare Data Exchange (HDX) on-line verification system at the end of another.

(Continued on page 20)

VIRTUA PATIENT ACCESS ACCURACY NOV. 2004

Employee Name	Total Regs	Acc/Occ	Insurance Address	Hosp Svc	Guar	Plan Code	Subs	ID#/ GRP#	PC/Ref	HDX	Verify Ins	Med?	Total Edits	Total Def Regs	Accuracy % Rato
Jones, Mary*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Brown, Susan	121	2	0	0	0	2	0	0	0	0	0	0	0	4	97%
Green, David	92	0	0	0	2	1	0	0	0	0	0	0	3	3	98%
Smith, Joseph	30	1	0	0	0	0	0	0	0	0	0	0	1	1	97%
Miller, Tony*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Price, Mona	57	3	1	0	0	2	0	0	0	0	0	0	3	3	95%
Rose, Rhonda*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Brown, Thomas	29	0	0	0	1	0	0	0	0	0	0	0	1	1	97%
Joseph, Edna	31	0	0	0	0	2	1	0	0	0	0	0	3	3	90%

Total Registrations:	**329**
Total PBS Edits:	**12**
Total PBS Deficient Regs:	**12**
Total PBS Accuracy Ratio:	**96%**

Legend:

Acc/Occ: accident/occurrence code
Insurance Address: mail to address of each insurance
Hosp Svc: hospital service/clinic code/patient type
Guar: guarantor
Plan Code: insurance plan code
Subs: subscriber to each insurance
ID#/ GRP#: ID# and Group# to each insurance
PC/ Ref: precert and referrals
HDX: HDX run and read
Verify Ins: Insurance verified indicator(FC only)
Med?: Medicare questionnaire
Total Edits: Total number edits the registrar made
Total Def Regs: Total number of deficient Registrations
Accuracy % Ratio: Def Regs divided by the Total Regs

100-95% Accuracy	15% Audit
94-90% Accuracy	30% Audit
89-0% Accuracy	60% Audit
New Hire	100% Audit

* No errors — perfect scores

Source: Virtua Health, Marlton, NJ.

"So if existing registrars needs reinforcement, they come in at the end of the day and get a refresher class [with the new hires]," Mastalski continues.

"It gives the new employees an opportunity to meet those who are already out in the field and makes for more interesting interaction," she says.

Another requirement for new hires is that, prior to the classroom training, they spend time at the campus where they will work, Mastalski adds.

"They're not on the computer; they may answer the phone, but basically they're there to observe. It gives them an opportunity to see what the job is about, but we realize it's a double-edged sword, if the person they're looking at has bad habits, they may pick them up," she explains.

To counteract that possibility, Mastalski says, "we start class saying, 'We're going to do things the correct way. If you've seen something different, let us know.'"

That initial campus time can be anywhere from eight hours to 20 or even 40 hours, she notes, depending on the person's availability and when he or she is hired in relation to when the next training session begins.

Evaluating training effectiveness

With all of the training pieces in place, Mastalski continues, scores on employee opinion surveys were "OK, but not as high as we had hoped. We didn't feel we were doing all we could to make training good for them."

With that in mind, training and development managers met with patient access leadership to decide on the next step, she adds.

They took a hard look at what the patient accounting department deemed the errors, or edits, that access was letting through and tried to find a way to improve accuracy by making better use of staff.

As a result, the auditor/educator position was created in late 2000, again without significant outlay for new employees, Mastalski explains.

"We realigned staff at each of our campuses to audit the registrations and do immediate education. We may have added one person," she says.

Seven auditor/educators cover the five hospitals, she notes, including two at each of three larger facilities, and one who covers two smaller hospitals.

The employees report to the campus manager, Mastalski notes, with a dotted line to the training and development team.

"The auditor/educators have a big job to do because they are at the front lines with the registrars," she says. "They spend about 25% of their time auditing and the remaining 75% performing the necessary education."

In addition to identifying areas of deficiency and targeting those problem areas with individualized, one-on-one training sessions," Mastalski continues, they are responsible for following a policy/procedure specifically geared toward registrar accuracy and accountability.

"In the past, there was finger-pointing based on the audit results," she says, "but now we utilize the results to reinforce one-on-one development of our most important asset: the employee."

Using a 12-point checklist, the auditors identify deficiencies in individual registrations and do one-on-one follow-up education, Mastalski says. "Then they monitor to see if more [instruction] is required. If so, they either do more one-on-one [training], or send the employee back to us for a refresher course."

The intensive monitoring and immediate education are "what makes us unique," she says, also crediting the Six Sigma data collection and process improvement tools the organization employs. **(See *Hospital Access Management*, November 2004, pp. 121-125.)**

The effort paid off in improved scores on the training and development section of the employee opinion surveys — which went from 75% in 2002 to 86% in 2004 — as well as a more efficient way to measure the effectiveness of training, Mastalski adds.

In the four years since the advent of the audit/educators, she points out, registration accuracy has increased from 78% to 97%, with the largest increase over the past two years.

"We do a percentage-based audit — a sampling, not 100% — and the people with lower accuracy rates have a higher percentage of their charts audited," Mastalski notes. **(See staff accuracy rates, p. 19.)**

Auditor/educators also are responsible for providing education at staff meetings, customer service training, registrar scripting, helping out with classroom training as needed, and conducting e-mail education, she adds.

"When we identify that many employees have the same deficiency in one of the insurances, for example, they put together an e-mail and send it to all the staff. It's a quicker and more efficient way to reach everyone when one-on-one education is not feasible," Mastalski explains.

Another training resource is a public folder in the departmental e-mail system that allows managers to keep files available for quick-and-easy reference by registrars, she adds.

"We have all our registration tools there, so that if a registrar needs, [for example], an address for an insurer, it's available. Any lists we use — our cheat sheets — are there," Mastalski says.

In addition, at least three times a year, training and development staff put out a newsletter geared specifically to patient business services employees, she notes.

"It may include information an insurance company has released, a breakdown of new training initiatives, or information on a new product we're putting in," Mastalski adds.

The staff newsletter is appropriately called "*The Journey,* because the journey starts with them. We strive for 100%, and if we don't start at the beginning, they'll never get there," she adds.

[Editor's note: Diane Mastalski can be reached at (856) 248-6369 or by e-mail at dmastalski@virtua.org.] ■

Service excellence begins with behavioral change

Initiative works because everyone owns it

"This is a journey; we'll know we've arrived when they don't need us anymore," says **Sandy Gregg**, RN, MN, MHA, director of service excellence for Providence Health System in Portland, OR. "My goal is to work myself out of a job."

Although Gregg's is a full-time position, the team that is responsible for implementing the message throughout the system's Oregon hospitals is not comprised of full-time service excellence employees, she points out.

"That's purposeful, because service excellence is not a role; it's the organization's work. So everyone owns it," Gregg says.

To further explain the concept, she first makes note of the strategic planning that takes place to determine the health system's visions and then the steps by which it will turn those visions into reality.

The service excellence initiative, she says, "is about *how* we do that work. It's not a goal in itself, but the culture in which we do our work."

Service excellence, Gregg continues, addresses not only the employees' technical skills but their behaviors.

"It's not just being technically competent, but being value-based and respectful." The service excellence team is responsible for setting what the expectations are for those standards and holding people accountable for them," she explains.

"We are committed to being the best place to work, the best place to be a patient, and the best place to practice medicine," Gregg says. In the Oregon region, of which the Portland service area is the largest component, that effort starts with chief executive Russ Danielson.

Providence has had strong quality programs in place since the 1980s, she says, so the focus on process improvement is not new.

However, in the past three or four years — with a formalizing of roles in September 2004 — the commitment has become, "We'll measure, communicate this, and build an infrastructure," Gregg adds.

There is the understanding, she explains, that for all Providence customers to have an excellent experience, "it takes every person in the room. It's about helping all of the staff to understand how they impact that experience, whatever their role is."

The service excellence initiative follows a model created by Quint Studer, founder of the Studer Group (www.studergroup.com) and author of the book *Hardwiring Excellence,* she notes.

In examining the goal of wanting all customers to have an excellent experience, Gregg notes, it's important to recognize that "some of our patients, as a group, are always more satisfied. When we look at the reason for that, we find out that it's not just technical. We find out that it's something about the staff on those floors."

Taking it a step further, she says, the question becomes, "Why are some groups of nurses so much more satisfied with their jobs?" The answer, she adds, "is almost always that they have a very good manager."

Every hospital needs to have "great medical care, good nurses, OK food, but meeting all those needs just gets you to a certain level of satisfaction," Gregg explains. "We're trying to find out how to get [patients on] every [nursing] floor [to the level of the most satisfied and] to

get the management skills that build a high performance level."

Over the last half of 2004, she says, Providence began obtaining monthly feedback on patient satisfaction, with plans for moving to weekly surveys in 2005. To get even more immediate feedback, the system is introducing discharge phone calls, Gregg adds.

Every patient who leaves the hospital — unless it is not appropriate for some reason — will be called within 48 hours in an effort to understand what their experience was, she says.

"If they tell us [the stay] was wonderful, we can thank them, and if the experience was not good, we can hear about it in a timely way and do whatever service is necessary," Gregg notes.

Implementing excellence

One way the health system is improving the quality of inpatient stays, she adds, is by placing in every person's room a white board on which pertinent treatment information is written.

Listed there, for example, are the nurse's name, if and at what time blood will be drawn, and when the physician will be in, Gregg says.

"If someone comes in to draw blood and that's not on the board, that's a quality check for us."

Providence also has a "5-10 rule," she says, meaning that employees must look at people who pass within 10 feet, and greet those who pass within 5 feet. "The idea is that no one is invisible. You don't break up a conversation, but you let people know that it matters that they're there."

Apart from being a courtesy, Gregg points out, the practice is "an amazing way of finding out who has walked into our facility. If you greet people, often they will ask you a question. It's a simple way to reach out to people who are really vulnerable."

Creating service excellence is about "key words at key times," she adds, and about every person who leaves an interaction asking, "What else can I do for you?" and meaning it.

"Regardless of your ZIP code, when you walk into Providence, we want your experience to be that people take the time to hear you," Gregg says. "It's the customer experience that's important to us."

[Editor's note: Look for a discussion of "operational excellence," a related Providence initiative, in a future issue of Hospital Access Management. *Sandy Gregg can be reached at (503) 215-7525.]* ■

Automated telephonic tool reduces pre-cert hassles

Time staff spend on hold slashed dramatically

An authorization system recently implemented at the University Hospital of Arkansas in Little Rock is on track to streamline the pre-certification process and reduce payer denials, explains **Holly Hiryak**, RN, CHAM, director of hospital admissions.

VoiCert, an automated, telephonic tool for obtaining authorization from payers for admissions, outpatient procedures, and ancillary services, waits on hold so registrars don't have to, combines multiple pre-cert requests into one telephone call, and provides documentation of authorization history, Hiryak adds.

"We have so many access points throughout the system where it's difficult for registrars to sit on hold for 15 or 20 minutes" waiting to get authorization for a procedure, she notes.

"Patients walk up, a physician needs you to do something, another phone is ringing — that's the reality when you have multiple clinics and a lot of different people trying to do the [pre-cert] work," she notes.

What sometimes happens, Hiryak says, is that people hang up to take care of other duties and forget to call the payer back, and the hospital ends up providing a service free of charge.

With VoiCert, she explains, the automated process works like this:

1. The registrar calls VoiCert and speaks the preliminary demographic and clinical information into the phone, hanging up when finished.
2. VoiCert calls the payer and waits in the holding queue for the payer representative to answer. Once contact is made, the payer representative listens to the demographic and clinical data and then records the authorization information. The representative also can record a request for additional information or connect directly with the provider for a discussion about a difficult case.
3. VoiCert delivers the authorization information to the registrar or to a prespecified voice mailbox. The information is stored permanently for future retrieval.

The system requires an average of 2.5 minutes of phone time per certification, she notes,

and pre-certification requests can be entered sequentially to multiple payers during one phone session.

Each payer may need slightly different information, but the way the prompt is set up, the person making the call doesn't have to know those differences, Hiryak says.

While not all of the hospital's payers are on the VoiCert system, she adds, the vendor works with the managed care staff, and does whatever is necessary to get payers set up.

What is the incentive for the payers? "They're graded based on calls received, wait time, and dropped calls," Hiryak points out. "This helps them get a better satisfaction rating."

"It's a pretty nifty tool," she says. "[Registrars] really like it. They get excited when they get that call back [with the authorization]. The good part is that all of this is recorded, so if a payer says, 'We didn't tell you that you didn't need a precept,' we can play the recording back for them. We can overturn denials."

The ability to monitor calls came in handy soon after implementation, during a holiday weekend when there also was inclement weather, Hiryak notes.

"One of the payers' voice mailbox was full, so we could not call in a notification. We now have the recording of the message saying that the box was full, so if the payer tries to deny, we have voice documentation that their system could not accommodate us," she adds.

The system also has the capability of recording outbound calls even if the registrar is on the line with a payer that is not on VoiCert, Hiryak explains.

"It announces to the payer that you will be recording the information. So again, if the payer comes back [disputing a pre-cert], you can play the recording," she points out.

Although the system is simple and easy to use, she notes, the vendor provides a "great implementation guide. They very much engage themselves with you to make sure [the tool] is meeting your needs and goals."

[Editor's note: Holly Hiryak can be reached at (501) 686-8170 or by e-mail at hiryakhollym@uams.edu.] ■

NEWS BRIEFS

Uncompensated care at $24.9 billion in 2003

U.S. hospitals provided $24.9 billion in uncompensated care in 2003, up from $22.3 billion in 2002, according to the latest American Hospital Association (AHA) Annual Survey of Hospitals.

The survey measure includes charity care and bad debt, valued at the cost to the hospital of the services provided. The amount of uncompensated care provided by hospitals has increased by $3.3 billion, or more than 13%, since 2000.

AHA president **Dick Davidson** said America's community hospitals always have found ways to help patients who can't pay their hospital bills because of limited financial resources and a lack of health insurance. But he said the major challenge facing America's health system is that 45 million people are uninsured.

The information on hospital uncompensated care comes from the AHA's Annual Survey Data, 1980-2003. ▼

NUBC seeks comment on billing data revisions

The National Uniform Billing Committee (NUBC), which maintains the billing data set for institutional health care providers, is seeking comment from hospitals and others on proposed revisions to the form and data set used to process health care claims.

The changes are intended to better align the form and data set with the Health Insurance Portability and Accountability Act's transaction standard and other national standards.

The NUBC will accept comments through Feb. 1, 2005, and plan to review comments at its Feb. 22-23

COMING IN FUTURE MONTHS

- A look at the new Medicaid waivers
- The access take on concierge medicine
- Are you ready for the HIPAA security rule?
- Tips for enhancing customer service
- More on effective denial management

meeting in Baltimore. A summary of changes to the billing form and data set, and a survey for submitting comments, are available at www.nubc.org/UB04.pdf. ▼

Senior health care costs affecting public funding

A recent report by the Centers for Medicare & Medicaid Services' Office of the Actuary concludes that higher relative health care spending by seniors, and their faster population growth will increase pressure on public funding of health care over the next several decades. People 65 and older made up 13% of the U.S. population in 1999, yet they consumed 36% of the nation's spending for health care of $387 billion, or an average $11,089 per senior, the report notes. As the elderly share of the population increases to a projected 21.3% by 2049, the study estimates personal health spending could grow by an average 0.5% per year, increasing pressure on public funding of health care. About half of the average $11,089 spent on health care for seniors in 1999 was paid for by Medicare, and about 15% by Medicaid, the study notes.

To read the report, *Age Estimates in the National Health Accounts*, go to www.cms.hhs.gov/review/default.asp. ▼

CMS: Discounts for uninsured patients OK

The Centers for Medicare & Medicaid Services issued much-anticipated additional guidance confirming that hospitals can offer discounts to any uninsured patients without putting the hospital's Medicare payments at risk.

The agency issued its first set of guidance in February, and responses from administration officials during a June open-door forum led hospitals to believe that offering discounts to any uninsured patient would be permitted and would not imperil Medicare payments.

However, the issue was reopened last fall. The new guidance, released as an FAQ (www.cms.hhs.gov/providers/FAQ_Uninsured_Additional.pdf), appears to confirm the information provided to hospitals last June that "individualized determinations of need" are not required to offer discounts to uninsured patients. ▼

CMS survey to assess satisfaction with FIs

The Centers for Medicare & Medicaid Services (CMS) is developing a new survey to assess providers' satisfaction with the services provided by fiscal intermediaries and other Medicare fee-for-service contractors.

A draft survey is being sent to roughly 7,400 Medicare providers, including hospitals, in multiple states. The 76-question survey, which CMS estimates will take 22 minutes to complete, asks providers to rate contractors on administrative functions such as provider inquiries, claims processing, appeals, medical review, reimbursement and other areas.

The findings will be used to fine-tune the survey instrument before a planned rollout to all Medicare contractors in 2006.

CMS plans to use the final survey instrument to help contractors improve the quality of their services, and create a performance-measurement standard for contracting purposes.

More information is available at www.cms.hhs.gov/providers. ■

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

Two HIPAA privacy provisions 'unnecessarily burdensome'

GAO report gauges provider reaction to privacy rule

A survey of providers, health plans, patient representatives, and others conducted by Congress' General Accounting Office (GAO) found providers and health plans believe that implementation of the HIPAA privacy rule went more smoothly than expected in its first year, but that two provisions of the rule are unnecessarily burdensome.

The providers and health plans raised issues about the requirements to account for certain information disclosures and to develop agreements with business associates that extend privacy protection downstream.

Consumer and provider representatives said the general public is not well informed about rights under the privacy rule, and more structured educational efforts are needed.

The GAO contended some evidence of patients' lack of understanding of the rule's scope and provisions may be reflected in the 5,648 complaints filed with the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) in the first year after the privacy rule became effective. Of the roughly 2,700 complaint cases OCR closed as of April 13, 2004, GAO said, nearly two-thirds fell outside the privacy rule's scope because they involved either accusations of actions not prohibited by the regulation, entities that are not covered under the regulation, or actions that occurred before covered entities were required to be compliant. Of the cases that were covered by the rule, OCR found that in 50%, no violation had occurred.

According to the GAO, provider groups stated that some physicians and hospitals remain unclear about what type of information may be disclosed for law enforcement purposes. Also, health plan representatives reported ongoing difficulties associated with knowing what state laws take precedence over the privacy rule.

The GAO said most provider and health plan organizations interviewed identified the requirement to account for certain disclosures as unnecessarily burdensome. The organizations reported that significant time and resources are needed to establish and maintain systems to track disclosures.

For example, various hospital departments keep patient information in separate systems not necessarily linked electronically. According to the Health Care Compliance Association, hospitals have had to review systems to establish electronic links or have had to create manual-tracking mechanisms. Similarly, health plan representatives reported many plans or insurers generally keep information related to one patient in multiple systems, making it difficult to track all information disclosures for that patient.

Provider and health plan representatives also expressed concern about the volume of disclosures that must be tracked, commenting that frequent, diverse disclosures required by law add significantly to the volume of information that must be tracked continually.

Many organizations GAO interviewed questioned whether the privacy rule accounting provision generates much benefit for patients. These organizations reported that their members have received few or no requests from patients for an accounting of the disclosures of their protected health information.

To somewhat reduce the burden of the requirement to account for disclosures, several organizations suggested that OCR modify the rule to require covered entities to inform patients in the privacy practices notice that when required by law, their information will be disclosed to public health organizations and law enforcement agencies.

The GAO said provider and health plan representatives reported that significant resources also

have been required to implement business associate agreements. The organizations said that some of the burden associated with implementing the provision stemmed from confusion and variation in determining which relationships with downstream entities require agreements.

Although the privacy rule provided for phased-in implementation of business associate agreement requirements to accommodate existing contracts, provider and health plan groups still viewed the business associate agreement provision as very burdensome, the GAO said.

Some organizations representing providers and health plans suggested that OCR provide more guidance to covered entities about when and how to enter into a business associate agreement. The organizations said OCR's existing guidance is not specific enough to assist providers and health plans with their agreements.

Patient advocates reported facing new obstacles when seeking access to protected health information on behalf of patients due to excessive paperwork, misunderstanding of the rule, and reluctance by providers and health plans to share information with legal aid attorneys, state ombudsmen, and others when the rule permits discretion.

Many organizations said patients are not aware of their rights under the privacy rule, either because they don't understand the notice of privacy practices or because they have not focused attention on privacy issues when notices are presented to them. In its conclusion, the GAO recommended that the secretary of HHS:

- modify the privacy rule to require that patients be informed in the notice of privacy practices that their information will be disclosed to public health authorities when required by law and exempt such public health disclosures from the accounting for disclosures provision;
- conduct a public information campaign to improve awareness of patients' rights under the privacy rule.

In written comments, the GAO said, the department agreed with the finding that implementation went more smoothly than expected and privacy procedures have become routine practice for many staffs.

In commenting on a recommendation that it conduct a public information campaign to improve awareness of patients' rights under the privacy rule, the agency agreed notices of privacy practices may appear too long and complicated and consumers may not be reading the notices closely. HHS said that the complaint data received by OCR may not indicate consumers are unaware of their rights under the rule, but rather that they don't properly understand their rights. HHS pointed to two new consumer fact sheets posted to its web site last August, a toll-free phone line to respond to questions about the rule, and efforts to encourage covered entities to develop consumer-friendly notices that highlight key information.

The GAO said a more diverse approach to consumer outreach may be necessary to effectively communicate the new privacy rights. Information available on the web site and through a toll-free phone line provide access to a portion of the general public, it added, but may not reach the many consumers who don't know of those sources. "We believe it is important that, in current and future efforts to educate the public, HHS more effectively disseminate information about protections provided under the privacy rule," the GAO said.

(Download the GAO report at www.gao.gov/cgi-bin/getrpt?GAO-04-965.) ■

Requirements on copying cost charges confusing

What costs are considered reasonable?

What used to be a fairly routine occurrence for many health care providers — supplying copies of patient medical records on request — is becoming a major issue under HIPAA because of questions about how much can be charged for a copy of the record and the service under the HIPAA privacy rule and various state laws.

Copies of medical records are requested routinely by patients changing providers, providers in connection with giving treatment to patients, and attorneys for use in legal cases. Under the privacy rule, covered entities (health plans, clearinghouses, and providers that transmit health information in electronic form in connection with a HIPAA covered transaction) are to inform individuals of their right of access to inspect and obtain a copy of their protected health information in the records maintained by or for the covered entity.

Rebekah A.Z. Monson, an attorney with Pepper Hamilton's Philadelphia office, tells *HIPAA Regulatory Alert* the privacy rule permits covered entities to charge "reasonable cost-based fees" for providing copies of protected health information to individuals or their personal representatives. Under the privacy rule, she says, fees for copies of medical

records only can cover costs of:

1. **copying**, including costs for supplies and labor;
2. **postage** if the individual has requested that the information be mailed;
3. **preparing an explanation or summary** of the information, but only if agreed to by an individual who has requested such a summary or explanation rather than the complete record.

The problem, Monson says, is in the preamble to the privacy rule, the Department of Health and Human Services wrote that while fees for copying and postage costs under state law are presumed to be reasonable, per-page costs that include costs excluded under the privacy rule, such as processing, retrieving, and handling charges, are not acceptable. As a result, she says, state-mandated fees for copying charges, or a portion of those fees, may be preempted by HIPAA and the privacy rule.

"Many state-mandated copying fees are higher than the costs involved in copying the information, and therefore, these fees may be pre-empted by the lower 'reasonable' cost standard," Monson says. "In connection with providing copies to individuals or their personal representatives, covered entities will need to carefully review the state-mandated fees and determine whether they meet the privacy rule reasonableness standard."

The department has not tried to give specific allowable cost figures because costs vary depending upon the size of the covered entity and the form of the copy, she adds.

Another area of confusion involves the fee charged individual patients, contrasted with the fee that can be charged for other requests or permitted disclosures, such as disclosures to a third-party pursuant to a patient authorization, which appear to fall outside of the scope of the privacy rule copy charge requirements.

"The department, in its comments on the privacy rule, intended to assure that a right of access would be available to all individuals and not only to those who can afford a copying fee," Monson says. "But there is a question of how an appropriate fee should be determined if, for example, an attorney is requesting the records as part of litigation. We've been hearing of some very high fees charged third parties when the copying is done in states that have limited or no controls over fees to be charged."

In general, under the privacy rule, the authority of patients' personal representatives to act on behalf of individuals stems from the representatives' authority to make health care decisions for the individual, such as through a health care power of attorney. That typically is not the case when attorneys are representing patients in lawsuits.

Also, the preamble to the privacy rule clarified that the department's intent was to enable individuals to have access to their protected health information. "We do not intend to affect the fees that covered entities charge for providing protected health information to anyone other than the individual," it said.

Monson says there have been reports of some malpractice plaintiffs attorneys asking their clients to request the information and have it sent to them for future delivery to their attorney, thus hoping to keep the cost of copying at the individual level.

She says there is confusion about the scope of HIPAA's copy charge requirements, particularly with respect to how they intersect with state law requirements, and would expect continued attention and possible litigation on these issues.

[Contact Ms. Monson at (215) 981-4031 or e-mail her at monsonr@pepperlaw.com.] ■

CMS issues first of seven security guidance papers

Paper provides security rule overview

The Centers for Medicare & Medicaid Services (CMS) has issued the first in a projected series of seven papers to provide guidance for covered entities. *Security 101* is an overview of the HIPAA security rule requirements and implementation and a preview of the remaining six papers.

The Security Series papers are designed to give HIPAA-covered entities insight into the security rule and assistance with implementation of the security standards, CMS said. "While there is no one approach that will guarantee successful implementation of all the security standards, this series aims to explain specific requirements, the thought process behind those requirements, and possible ways to address the provisions."

All HIPAA-covered entities must comply with the security rule. Compliance deadlines are April 20, 2005, except for small health plans, which have until April 20, 2006.

In explaining the rationale for the security rule, CMS noted that before HIPAA, there was no generally accepted set of security standards or general requirements for protecting health information. At the same time, new technologies were evolving,

and the health care industry was beginning to move away from paper processes and rely more heavily on the use of computers to pay claims, answer eligibility questions, provide health information, and conduct many other administrative and clinically based functions.

The security rule differs from the privacy rule in that the privacy rule sets standards for, among other things, who may have access to protected health information, while the security rule sets the standards for ensuring that only those who should have access to electronic protected health information actually will have access. CMS said that with the passing of deadlines for both the privacy and electronic transactions and code set standards, many covered entities now are turning their attention to the security requirements.

An "implementation specification" in the security rule is a detailed instruction for implementing a particular standard. Each set of safeguards is comprised of a number of standards that, in turn, generally are comprised of a number of implementation specifications that are either required or addressable.

For required implementation specifications, covered entities must implement policies and/or procedures that meet what the implementation specification requires. For those that are addressable, covered entities must assess whether they are reasonable and appropriate safeguards in the entity's environment. That involves analyzing the specification in reference to the likelihood of protecting the entity's electronic protected health information from reasonably anticipated threats and hazards. Covered entities that choose not to implement an addressable specification must document the reasons and implement an equivalent alternative measure if that measure would be reasonable and appropriate. CMS said decisions on which security measures to implement to address the standards and implementation specifications will depend on a variety of factors, including the entity's risk analysis, security analysis, and financial analysis.

At a minimum, the process for complying with the security rule should involve assessing current security, risks, and gaps; developing an implementation plan; implementing solutions; documenting decisions; and reassessing periodically, the agency said. The security requirements were designed to be technology-neutral and scalable from the very largest of health plans to the very smallest of provider practices. CMS said covered entities will find that compliance with the security rule will require an evaluation of what security measures currently are in place, an accurate and thorough risk analysis, and a series of documented solutions from a number of complex factors unique to each organization.

"HHS recognizes that each covered entity is unique and varies in size and resources, and that there is no totally secure system," it added. "Therefore, the security standards were designed to provide guidelines to all types of covered entities, while affording them flexibility regarding how to implement the standards. Covered entities may use appropriate security measures that enable them to reasonably implement a standard. In deciding which security measures to use, a covered entity should take into account its size, capabilities, the costs of the specific security measures, and the operational impact. For example, covered entities will be expected to balance the risks of inappropriate use or disclosure of electronic protected health information against the impact of various protective measures. This means that smaller and less sophisticated practices may not be able to implement security in the same manner and at the same cost as large, complex entities. However, cost alone is not an acceptable reason to not implement a procedure or measure."

Security standards are divided into administrative, physical, and technical safeguards. Generally, administrative safeguards are the administrative functions that should be implemented to meet security standards, including assignment or delegation of security responsibility to an individual and security training requirements. Physical safeguards are those mechanisms required to protect electronic systems and equipment and the data they hold from threats, environmental hazards, and unauthorized intrusion, including restricting access to electronic protected health information and retaining off-site computer backups. Technical safeguards primarily are the automated processes used to protect data and control access to data, including using authentication controls to verify that the person signing onto a computer is authorized to access the electronic protected health information or encrypting and decrypting data as they are being stored and/or transmitted.

Other papers in the series will cover administrative safeguards, physical safeguards, technical safeguards, organizational policies and procedures, and documentation requirements.

(For information and copies of Security Series papers, go on-line to www.cms.hhs.gov/hipaa/hipaa2.) ■