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IN THIS ISSUE

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NC hospital uses Six Sigma initiative to train staff and target bad debt

Patient financial services team approach gets great results

Wake Forest University Baptist Medical Center in Winston Salem, NC, joined the growing ranks of health care organizations implementing the innovative quality assurance and process improvement strategy — Six Sigma.

Keith Weatherman, CAM, MHA, associate director of patient financial services (PFS), is part of three Six Sigma teams — one for bad debt reduction, one for emergency department collections, and another for ancillary collections — and says the program already has had a dramatic impact.

"I can see silos literally crashing down," he says. "People are appreciating people; there's a team approach. If we stopped now and didn't do anything else, I'd say it had been worthwhile."

One of the most notable aspects of the Six Sigma strategy is its use of individuals — trained as "black belts" — who work full time as team leaders. **(See related article, *Hospital Access Management*, November 2004, p. 124.)**

That commitment "shows the administration is taking it that seriously," Weatherman adds. "It isn't one of those flavor-of-the-month things. It's here to stay."

Instant credibility

Projects begun under that kind of sanction have instant credibility, he notes. "Trying to get team members from certain departments is not an issue. Everybody is willing — that's the biggest thing. It's not a PFS problem or opportunity; it's an organizational opportunity."

Heading up the 15-member bad debt reduction team at Wake Forest is **Kyle Nifong**, one of six people hired and trained as black belts. Formerly employed in the information systems (IS) department, Nifong says moving from the IS arena into Six Sigma has been a great learning experience.

"I did a lot of project management before, but it was in information technology," he notes. "This is a functionally based project. Six Sigma is a data-driven process that brings so many tools to the table. Instead of ideas being based on hunches, they're really based on data. It gives you a broader perspective."

In pursuit of bad debt reduction, Nifong explains, the Six Sigma team addressed the number of cases written off to bad debt and their dollar amount.

"We looked at the causes: Most bad debt is from copays, deductibles, and coinsurances that don't get paid. Our goal," he adds, "is to try to get more of those payments prior to the patient leaving the medical center."

After using Six Sigma tools to identify the problem, Nifong continues, the team determines which functions it will repair.

"We've identified several causes, but we try to focus on getting one particular thing fixed," he explains.

In this instance, the desired outcomes became:

- getting payment of whatever the copay is at the time of discharge;
- making arrangements for a payment plan if necessary;
- verifying the patient's address, based on the knowledge that returned mail is a nationally recognized issue for hospitals.

In setting up a pilot project — or what is known in Six Sigma's manufacturing world as "design of project" — the team targeted two of the specialty areas with the highest bad debt ratio, Nifong says.

One of the key issues being addressed by the project, notes Weatherman, is the increasing number of patients who are not scheduled in advance, but come to the hospital as direct admits.

Limited time for discharge planning

With emphasis on customer satisfaction leading to more patients going directly to their rooms, he adds, "there's not as much time to get everything done, [such as having] that leisurely interview with the patient."

At Wake Forest, Weatherman points out, only 25% of inpatients come through the admitting office.

Shorter lengths of stay mean access representatives sometimes aren't able to get to every patient's room before discharge to review financial and demographic information and, if necessary, arrange for payment, he explains.

A cardiology patient who is out of his/her room having a procedure done, for example, might fall through the cracks of the registration process, Nifong notes.

"In the past, we could have preadmitted them [and] worked upfront. But now we have to change our processes to figure out how to do the work while the patient is here," Weatherman says.

As part of the pilot project, Wake Forest has set up a discharge station near the door where inpatients leave the hospital to go to the parking area, he explains.

With assistance from nursing and transportation

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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**.

personnel, departing patients — instead of being discharged directly from the nursing unit — will go by the new discharge area, adds Weatherman .

"Financial counselors can talk to the patient, make sure all the information is up to date, and make payment arrangements," he says. "It's a final check."

In this way, Weatherman notes, accounts that might otherwise have become uncollectible — because, for example, a secondary insurance was not identified early enough or an address was no longer valid — can be verified.

Six Sigma steps

Vice presidents over different areas of the hospital submitted suggestions for what the first Six Sigma projects would be, Weatherman says, with a priority put on those that would help the bottom line most.

While PFS is taking a leadership role in the bad debt and collections projects, he points out, its personnel also are serving on teams that are championed by other departments, such as one that is focused on operating room scheduling.

Six Sigma projects are owned by the appropriate vice president, or champion — in this case, Wake Forest's vice president of finance, Nifong explains.

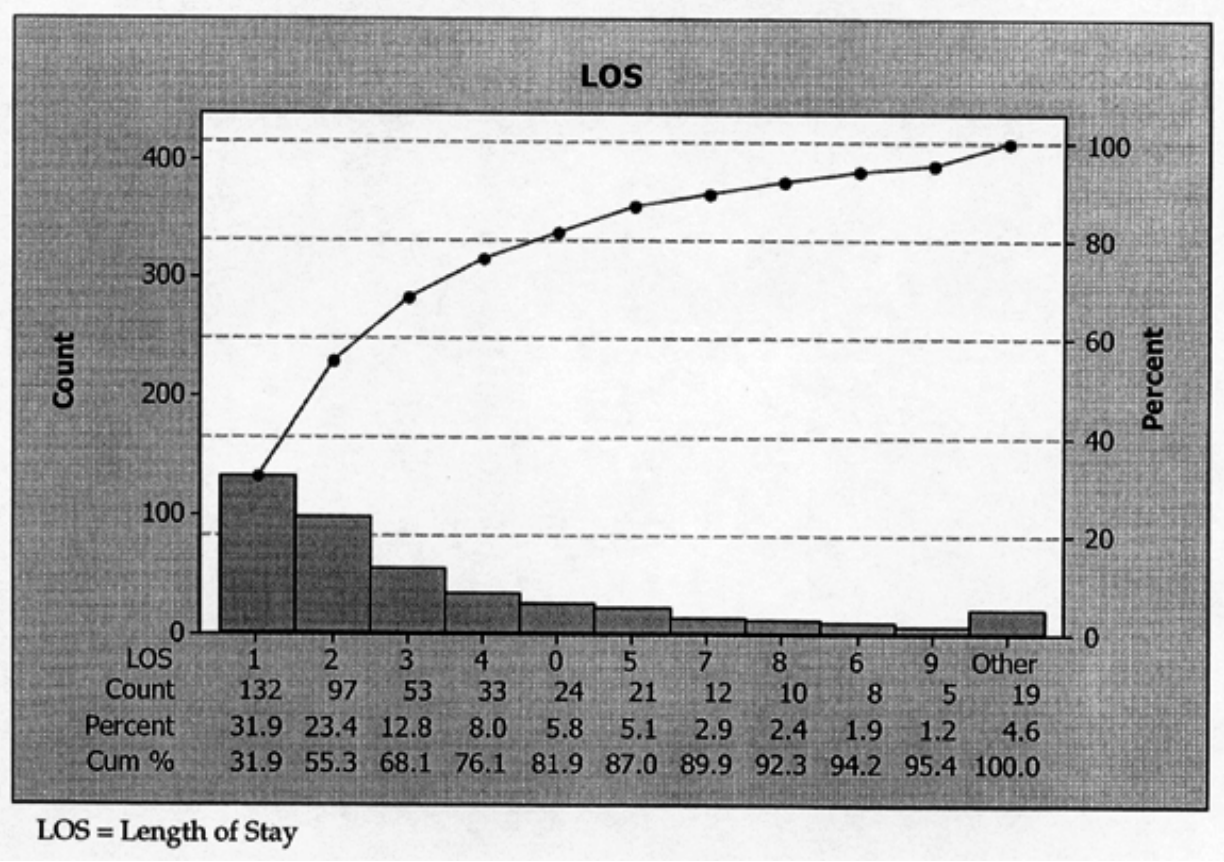
A team is assembled by the owner of the actual process involved, who is someone at the director level, he adds. For the bad debt reduction project, that person was the PFS director.

To identify the causes of the problem, Nifong explains, the team completes a diagram showing Steps A-Z, and asks, "What are the key areas involved? Does [the problem] cross over another area?"

An example of that overlap, he says, is the patients being registered by admissions staff, their information sent to the insurance verification area, and then going to a financial counselor to discuss payment options.

Once that process is identified, Nifong adds,

Length of Stay of Bad Debt Patients



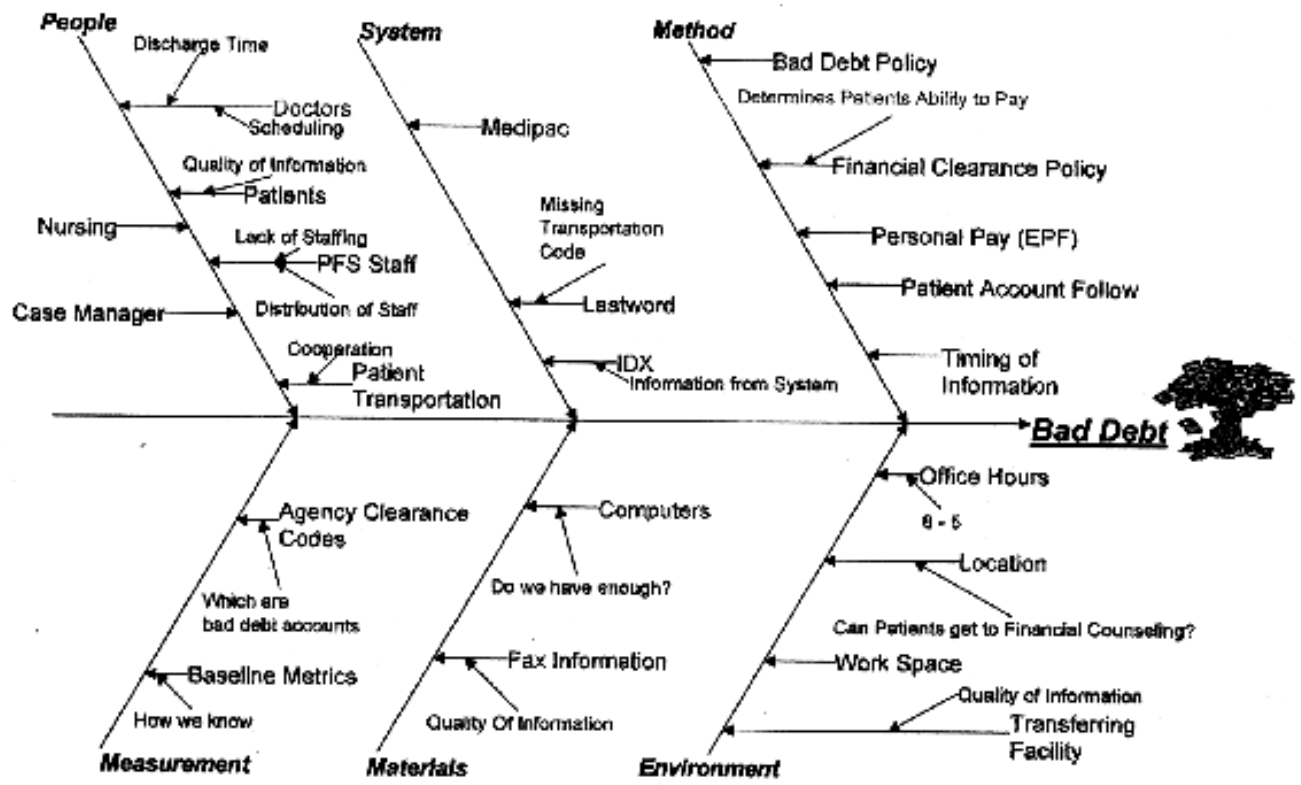
LOS	1	2	3	4	0	5	7	8	6	9	Other
Count	132	97	53	33	24	21	12	10	8	5	19
Percent	31.9	23.4	12.8	8.0	5.8	5.1	2.9	2.4	1.9	1.2	4.6
Cum %	31.9	55.3	68.1	76.1	81.9	87.0	89.9	92.3	94.2	95.4	100.0

LOS = Length of Stay

Source: Wake Forest Baptist Medical Center, Winston Salem, NC.

Cause-and-Effect Tool

Fishbone Diagram



Source: Wake Forest Baptist Medical Center, Winston Salem, NC.

the team examines the data (using bar charts, for example) to do a graphical analysis. **(See LOS graph, p. 27.)**

"Then we do a statistical and mathematical analysis that looks at different models to see what the data are showing as a potential problem, he says.

Minitab is a software tool commonly used by Six Sigma practitioners that helps with statistical and data analysis, he points out. (For more information on this product, go to the Minitab web site at www.minitab.com.)

"After we identify the data that might be pertinent, we use a fishbone diagram to help facilitate a brainstorming session," Nifong says. **(See fishbone diagram, above.)** "We look at the loopholes, then do a cause-and-effect matrix. For each cause, we list an effect."

A bad address is an example of a cause, he adds, and the effect is returned mail — and duplication of work.

Information from the cause-and-effect process is put into the failure mode effect analysis (FMEA), Nifong continues. "It's a powerful tool for narrowing down what the potential problems are. 'Y' is bad debt, and the 'Xs' are the causes of bad debt. You come up with the top ones that you intend to repair."

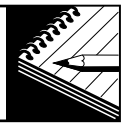
Using the FMEA, he says, the team identifies the key functional areas to work on — in this case, getting payment at the time of discharge and verifying the patient's address at discharge — and sets up the pilot.

"With Six Sigma, you make sure there is a tracking mechanism," Nifong notes. "You compare your graphs with the original graphs to see if the percentage of bad debt goes down."

The difference is in the level of detail, he adds. "You make sure you have had the gains and successes you forecasted."

(Editor's note: Keith Weatherman can be reached at kweather@wfubmc.edu. Kyle Nifong can be reached at rknifong@wfubmc.edu.) ■

GUEST COLUMN



Does request for data meet the HIPAA test?

Health care attorney offers guidelines

By **Loren Ratner**
Nixon Peabody LLP
Garden City, NY

[Editor's note: The analyses and conclusions contained in this article are limited to review of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations. It is essential that state laws and regulations in your state also be reviewed to determine whether they contain any additional requirements and whether any applicable provisions preempt the HIPAA privacy regulations, i.e., if the state law relates to the privacy of individually identifiable health information and provides greater privacy protections for individuals' health information or greater rights to individuals with respect to that information, than the privacy regulations do.]

Almost two years after implementation of the final HIPAA privacy regulations, a review of hospitals' experience with the regulations and a discussion of some common issues that arise in hospital settings is timely and appropriate.

All health care providers in the country were required to comply with the regulations, commonly referred to as the privacy rule, by April 14, 2003.

Preparation for compliance was a major undertaking for most providers. It began weeks and months earlier and progressed to a feverish pitch until the implementation date; things have calmed considerably since that time.

The nation's hospitals and other covered health care providers have established HIPAA privacy policies and procedures, provided HIPAA training to their employees, notified their patients of their privacy practices, and satisfied the many other requirements provided in the privacy rule.

Still, despite the best planning, the clearest policies, and the most comprehensive procedures, hospitals receive numerous requests for disclosure of protected health information (PHI) that were not anticipated in advance.

Here is discussion of a few such requests from HIPAA:

Question: When and to whom can information pertaining to deceased patients be disclosed without an authorization, and who can authorize other disclosures?

Answer: A hospital may receive requests for PHI pertaining to a deceased patient from various individuals and for diverse reasons. For example, requests may be received from family members, physicians and other health care providers, and attorneys. The hospital's ability to make the requested disclosure varies according to the facts and circumstances of the request, as exemplified by the following scenarios:

Dr. Jones requests PHI from Medical Center pertaining to a deceased patient, John Doe. The request is made on behalf of Susan Smith, the adult child of John. Can the PHI be disclosed to Dr. Jones?

If Dr. Jones' request is made to provide health services or treatments to Susan, Medical Center can disclose the relevant PHI. The privacy rule provides that PHI pertaining to a deceased patient that is relevant to a relative's health care can be disclosed to the relative's health care provider without a HIPAA-compliant authorization. The disclosure of the information is for treatment purposes [and is] a type of disclosure permitted under the rule.

Susan Smith submits a written request to Medical Center's medical records department asking for a copy of her deceased father John's medical records.

Medical Center is not permitted to disclose PHI pertaining to John in response to Susan's request, which is for a use not specifically permitted by the privacy rule. This is in contrast to permitted uses, such as treatment described above. Susan may have any one of a number of reasons for desiring the information. For example, she may be requesting the records to gain information to determine whether to bring a medical malpractice lawsuit.

Unless it is a disclosure specifically permitted by the privacy rule, however, Medical Center cannot disclose the PHI without a proper authorization that satisfies HIPAA's privacy rule.

In response to Medical Center's denial of Susan's request, as described in the previous paragraph, Susan agrees to authorize the disclosure, as John's adult child.

Can Medical Center release the PHI?

Unless Susan is the executor or administrator of John's estate, or is otherwise legally authorized to act on behalf of John or his estate, Medical Center cannot act on Susan's authorization for disclosure. Such authorization can be provided only by John's "personal representative."

A deceased patient's personal representative is the deceased patient's legally authorized executor or administrator, or a person who is otherwise legally authorized to act on behalf of the deceased individual or his estate.

A deceased patient's personal representative, as defined by the privacy rule, is provided the same rights under the rule as the patient himself would receive, if alive. Because John's personal representative is afforded the right to authorize disclosure of the PHI, Medical Center can disclose the PHI only with John's personal representative's authorization. Such authorization must be fully compliant with the privacy rule. In conclusion, Susan's request must be denied unless John's personal representative authorized such disclosure. Susan will have to use other legal avenues to obtain the information.

Question: Is a hospital permitted to release PHI to ambulance providers? What happens when Acme Ambulance Company requests information pertaining to Ed, a patient brought by Acme to Medical Center's emergency department, to enable it to pursue reimbursement from insurers?

Answer: Medical Center can respond to Acme's request for information pertaining to Ed, when the information requested to be used by Acme is to pursue payment for the services it rendered to Ed. Ambulance providers frequently transport patients who are unconscious or otherwise unable to communicate essential information with the ambulance staff, and the ambulance providers need patient information to submit claims for reimbursement.

Some hospitals have been uneasy about disclosing patient information to the ambulance providers, and a few have even considered treating such ambulance providers as business associates to ensure that PHI is fully protected in accordance with the privacy rule. Such measures are not necessary, as hospitals are permitted to disclose PHI to another health care provider for the payment activities of that provider.

In making requests for disclosures of PHI, covered entities are required to limit their requests for information to the minimum necessary. Ambulance providers should limit their requests accordingly to information necessary to enable them to seek payment.

In summary, because the request for PHI is for a payment purpose, Medical Center can release the information to Acme.

Question: Under what circumstances can a hospital disclose information pertaining to patients to police officers?

Answer: Police officers and other law enforcement authorities frequently seek information from hospitals pertaining to patients in various circumstances. Hospital privacy officers need to know the circumstances under which they are permitted to disclose PHI to law enforcement without a court order or other legal directive. HIPAA addresses several different such situations as follows:

Police Officer arrives at Medical Center seeking information pertaining to patient Polly, to investigate an allegation that Polly assaulted another patient

Medical Center is permitted to disclose PHI to Police Officer what Medical Center believes, in good faith, constitutes evidence of criminal conduct that occurred on the premises of Medical Center. Medical Center, however, must limit its disclosure of PHI to the minimum necessary for reporting of the crime to Police Officer.

Police Officer requests information about Polly because she is suspected of committing a serious crime and recently was a patient at Medical Center.

Medical Center may disclose certain information to Police Officer regarding Polly. Under the privacy rule, PHI may be disclosed in response to a request by law enforcement for the purpose of identifying or locating a suspect, fugitive or material witness, or a missing person.

The PHI disclosed is limited to the following: patient's name and address, date and place of birth, Social Security number, blood type (ABO and Rh factor), type of injury, date and time of treatment, date and time of death (if applicable), and a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos.

Information pertaining to the patient's DNA, dental records, or typing, and samples or analysis of body fluids or tissue cannot be disclosed for the purpose of identification or location of a suspect,

a fugitive or material witness, or a missing person.

Police Officer requests information from Medical Center pertaining to Velma, believed to be the victim of an assault that precipitated her hospitalization at Medical Center.

If certain conditions are met, Medical Center is permitted to disclose information about Velma to Police Officer. The privacy rule permits a health care provider to respond to a law enforcement official's request for information about an individual who is, or is suspected to be, a victim of a crime.

Prior to disclosure by the hospital, either the patient must agree to the disclosure, or if the patient cannot agree to disclosure because of incapacity or other emergency circumstances, the following condition must be satisfied. The law enforcement official must:

1. represent that the information is needed to determine whether a violation of law by a person other than the victim has occurred and the information is not intended to be used against the victim;
2. represent that the immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the patient can agree to disclosure.

In addition, the disclosure must be in the best interests of the individual, as determined by the hospital, in the exercise of its professional judgment. We recommend that Medical Center's privacy officer make this determination based upon the information available and in consultation with any appropriate individuals (such as legal counsel). Further, Medical Center should document such determination along with the required representations of Police Officer in Velma's medical record.

Responding to HIPAA privacy issues has become a routine part of hospitals' daily activities. While most HIPAA activities are routine and uneventful, requests and issues do arise that require a careful review of the circumstances and consideration of the requirements of the privacy rule and any applicable state laws and regulations. A hospital can best protect itself by staying up to date on HIPAA issues, including unusual requests for disclosure of patients' PHI.

(Editor's note: Loren Ratner is an attorney specializing in health and hospital law in the Health Services Group of Nixon Peabody LLP, in its Garden City, NY, office.) ■

Arkansas hospital easily goes 'smoke free'

Months of planning paid off

The campus of the University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock went "smoke free" last summer in a seamless transition that surprised and delighted access management.

"We had thought it was going to be a bigger problem than it really was," says **Mary Nellums**, CHAM, admissions manager for the medical center.

While she had been concerned that her staff might be faced with people angry about no longer being able to grab a smoke just outside the hospital exits, that situation never materialized, Nellums explains. "There was not one single complaint. It turned out to be a minor problem for patients and families. I was really, really shocked."

The smooth implementation of the smoking ban might have been due, in part, to extensive preparation on the part of hospital officials, who began planning for the event months before the effective date of July 6, 2004.

"Support came from the top," notes **Holly Hiryak**, MNSc, RN, CHAM, director of hospital admissions. "They actually hired a part-time temporary employee to implement the program, and her role was to meet with people to identify potential problems and develop fliers and other marketing materials.

"She came in with a limited focus, and then her role ended in August," she adds. "It did take the energy of having someone dedicated to [the implementation]."

Weeks in advance, signs heralding the transition to a smoke-free campus were posted throughout the campus, Hiryak says, with maps outlining smoke-free areas. Notices were put on the UAMS web site, included in mailings to patients with clinic appointments, and placed "pretty much anywhere a patient might access information."

Access personnel were trained to handle patients or family members who were upset about the ban, Nellums says, and access areas were provided with nicotine gum to distribute to those who requested it.

A process for signing out was devised so the hospital could track who was getting the gum, Hiryak says. "I don't think we had to use any, or

if we did, it was minimal," she says. "We had guidelines in place, such as patients waiting for admission or to be seen in the emergency department would not be given gum. That would be a clinical decision.

"However, if a family member or friend needed the gum, we could provide it," Hiryak explains. A script was prepared for access personnel, she adds, suggesting language for reminding people of the smoking ban and explaining how to use the gum.

"We could only dispense a limited amount," she adds, "and there was a disclaimer they had to sign, accepting responsibility for taking the gum. It mentioned possible side effects."

Hiryak says she remembers nothing more than "a little grumbling" in response to the smoking ban. "I was concerned that our frontline employees who deal with waiting families — people in crisis — would take the brunt" of what could be a strong negative reaction. "But we did all that education, and it just never was an issue."

"We put the nicotine gum in a safe, and never had to use it," adds Nellums. "I can't remember one patient or family member challenging us."

The UAMS administration eventually provided a "smoke shelter" for patient use, which required a written order, Hiryak says. "For the first few weeks, I saw people in that area, but now I hardly ever see anyone there. It's almost like people have gotten over it.

"I think employees had more problems with it than patients and families," she notes. "However, there were some employees who actually quit smoking."

To aid in that effort, UAMS began conducting a four-level smoking cessation program in April 2004, three months before the effective date of the ban, Hiryak says. A notice on the organization's web site, on tent cards in waiting areas, and in other locations offered four options for kicking the habit:

Level 1
Six-week, over-the-counter nicotine replacement therapy (NRT). This level is designed for those who feel they need no assistance other than NRT.

Level 2
Cessation materials provided with a brief assessment for alternative NRT and use of the toll-free Quitline cessation counseling service offered by the Arkansas Department of Health.

Level 3
This level is designed for employees and students who need additional help. It includes smoking cessation counseling through the employee assistance program, as well as mental health services for students.

Level 4
Smoking cessation program. Components of this comprehensive model include a trained facilitator who provides support with cessation materials, behavior modification principles, information on prescription management, and group/peer support. A six-week free membership at War Memorial Fitness Center also is included at this level.

Levels 1-4 were offered free of charge to UAMS employees and students, while non-UAMS employees were eligible only for Level 4.

Even employees who expressed no interest in quitting have had to cut down, Nellums points out. "They couldn't go that far to smoke."

[Editor's note: Holly Hiryak can be reached at (501) 686-8170 or by e-mail at hiryakhollym@uams.edu. Mary Nellums can be reached at (501) 686-6789 or by e-mail at nellumsmaryc@uams.edu.] ■

Access managers discuss impact of concierge care

Will fee-for-service system return?

Fee for service is making a comeback, contends health care futurist **Leland R. Kaiser**, who predicts health care is destined to become the leading business in America. A growing number of physicians are treating patients who pay them monthly or yearly fees — a retainer, in other words — for such benefits as not having to wait for appointments, controlling the procedures or medications they want, and even house calls and 24-hour access. This new practice is called "boutique" or "concierge" medicine.

Some retainer practices accept insurance for covered expenses, and the monthly or annual fees are for perks such as the house calls and no-wait appointments. Other practices refuse insurance altogether, and patients pay for all medical expenses in addition to the retainer fee.

The American Medical Association (AMA), in its guideline on retainer medicine, determined that such practices "appear to be consistent with a system based on pluralistic means of financing and delivery of medical care."

Under AMA principles of medical ethics, physicians are "free to choose the environment in which to provide medical care" and, except for emergencies, are free to choose their patients.

The AMA urges that a retainer provider not present the arrangement as a way to more or better diagnostic and therapeutic services, however.

The standard of care cannot be based on a patient's ability to pay, so a discrepancy in the quality of medical decisions in a mixed practice (in which the provider treats retainer patients and insurance-only patients) "would be particularly condemnable," the AMA guidelines state.

On the other hand, the AMA adds, it is possible that the personalized attention and patient satisfaction that could result from a retainer arrangement could lead to better patient-physician communication and patient compliance, which could improve outcomes in certain cases.

The response from insurance companies has been mixed. Some networks are including concierge practitioners in their network of providers (still only paying for regular, covered expenses).

Others have determined that the idea of retainer contracts is in opposition to their mission to provide health care to as many people as possible and for member physicians to accept new health plan members without restrictions.

Kaiser says, in a democratic, capitalistic society, people with more means should be able to spend it any way they please — whether on a new car or concierge medical care. He was quoted in a recent issue of *Physicians Practice Digest* as predicting that, within a decade, between 30% and 40% of all physician visits will be fee-for-service visits.

Access professionals cautious and skeptical

Access professionals asked to share with ***Hospital Access Management*** their opinion of this emerging practice came down mostly on the side of caution or skepticism.

Pete Kraus, CHAM, business analyst for patient accounts services at Emory University Hospital in Atlanta, calls arguments made in support of concierge medicine "a curious mix of common sense and out-of-touch fantasy."

Evidence of a fee-for-service comeback may well reflect a trend of sorts, Kraus agrees, noting that people of means can, and do, pay out of their pockets for extra health care services. "There's nothing wrong with that.

"As Dr. Kaiser points out, they have the right to spend their money any way they want," he notes.

Kraus says he's also OK in principle with the assertion by Kaiser that increases in health care spending reflect a legitimate growth of the economy. "If that's where demand is, so be it. It's a little off-putting that he does not seem interested in studying the causes of growth as a potential means of cost control."

He contends, however, that Kaiser possibly enters the realm of fantasy if he believes controlling costs by restricting expensive services to those who can pay out-of-pocket should drive public policy.

"The general population may not object to the rich buying a big house, a fancy car, or a boat," Kraus adds. "It's something to which everyone can aspire. But health care is more basic. To the extent that effective but costly procedures become part of the routine standard of care, people expect their insurance plans to cover them."

Some physicians, such as **John Blanchard**, MD, however, say what critics call "wealthcare" is just putting control of health care back in the hands of patients. He says the relationship between patients and physicians today is almost adversarial, and he blames that on our system of health insurance.

"Essentially, health care is not subject to free-market forces," says Blanchard, whose practice has offices in Clarkston and Grosse Pointe Woods, MI.

"Two competing primary care physicians are not really competing with each other. They sign up with an insurance company, and they get all these patients. But the competition is at the insurance level, not at the provider level," he notes.

With that scenario, Blanchard contends, "you drive down quality and drive up cost. A free market drives down cost and drives up quality."

In its 2002 Council on Ethical and Judicial Affairs report on retainer medicine, the AMA addresses the dilemma posed when a traditional practice converts to retainer care

"If a practice switches from regular, insurance-paid care to retainer care, and low-income patients can't afford to sign on, does that create a burden for the patients?" the report asks.

Blanchard says he and other retainer practitioners build subsidized care and free care into their practices, to maintain their ethical responsibilities to render care to those in need. "If people can't afford my practice, they pay what they can afford."

Beth Keith, CHAM, senior management consultant with Superior Consultant Company Inc., notes, with the tendency of all things to cycle, a return to a fee-for-service model is possible.

She predicts, however, that if group health plans made the changes foreseen by Kaiser, the result would be a distinct, two-tier system that would be detrimental to many health care organizations.

"Many facilities struggle now to maintain under the deep discounts for managed care," Keith points out. "If all the people who can afford to pay go elsewhere, you would be left with only the limited, no-pay patients, and that will not sustain an organization."

"If memory serves me correctly," she adds, "the opponents of national health care coverage used this very example — the ability of the rich to go to fee for service and everyone else getting another level of care — as being one of the major reasons we should not embrace that form of coverage."

While the discussion of concierge medicine at present centers around physician practices, Keith says, she cannot confine her perspective to that part of the health care environment.

"I believe the impact to health care institutions could be serious," she says. "The highly touted boutique facilities will take all the paying patients, and the remainder of the facilities will suffer financially — some, I am afraid, to the point of closing."

Gillian Cappiello, CHAM, senior director for access services and chief privacy officer at Chicago's Swedish Covenant Hospital, agrees that a shift to the scenario described by Kaiser "certainly would impact hospitals.

"There are social, rather than access, issues here" she says. "Although access in the greater sense would be an issue if there were not enough physicians to see the managed care, state and federally funded, or uninsured poor patients.

"We need to find a way to incorporate both [types of care]," Cappiello suggests. "I don't disagree with the concept so long as physicians had to see some of all kinds of patients and provide a certain amount of free care." She notes, while "everyone is fed up with managed care, the problem lies with the insurance companies getting rich from it, not with access and choices."

Kaiser and other proponents of this free market form of medicine say a standard of excellence should be met in all cases — in the same way, those who go to Taco Bell should expect good food, even if they can't afford to eat at the Ritz-Carlton Hotel.

Kraus says such talk of quality of care for all tiers sidesteps the issue. "[Kaiser] is correct that quality should not be cost-driven, but potential denial of services is a far more contentious issue.

"Health insurance is supposed to be about pooling risk so people of ordinary means can get the services they need, even if the cost is extraordinary," he adds. "Dr. Kaiser's comments do not satisfactorily address the shortcomings of our system as it is currently practiced."

(Editor's note: Pete Kraus can be reached at Pete_Kraus@emoryhealthcare.org. Beth Keith can be reached at Beth_Keith@superiorconsultant.com. Gillian Cappiello can be reached at GCappiel@schosp.org.) ■

NEWS BRIEFS

HCA changes policies for discounting care

Hospital Corp. of America Inc., (HCA) the nation's largest hospital company, said it has modified its policies on discounting patient care as of Jan. 1, 2005, based on recent guidance from the Centers for Medicare & Medicaid Services (CMS).

The company, which has about $17 billion in annual revenues, will provide a discount to any uninsured patient receiving nonelective care who does not qualify for Medicaid or charity care. The CMS guidance, issued in late December 2004, confirmed that hospitals can offer discounts to any uninsured patient without putting the hospital's Medicare payments at risk.

Another health care group, Triad Hospitals Inc., will expand its discount policy for self-pay patients effective April 1, 2005, to give all self-pay patients an initial discount off their total hospital bill, regardless of ability to pay. The discount will be commensurate with the local managed care discount at each hospital, the company said.

The new CMS guidance, released as an "FAQ," appears to confirm the information provided to hospitals last June that "individual determinations

of need" are not required to offer discounts to uninsured patients.

In March 2003, HCA implemented a sliding scale of discounts for uninsured patients with incomes between 200% and 400% of the federal poverty level.

Under the new policy, HCA said its hospitals will attempt to qualify uninsured patients for Medicaid, other federal or state assistance, or charity care. If a patient does not qualify for those programs, the hospital will apply a discount similar to those it provides to local managed care plans.

"While these policy changes will help individual uninsured patients in many cases," said HCA chairman and CEO **Jack Bovender Jr.**, "it will not solve the underlying issue of uninsured Americans. This country needs a broad-based solution to this problem."

Last October, Triad implemented a policy offering discounts to self-paying uninsured patients with limited ability to pay, with the discount based on each hospital's location and each patient's ability to pay. Triad initially offered the discount to all uninsured patients, but discontinued that component after comments by CMS that suggested it could affect Medicare reimbursement.

"CMS recently clarified its position, and the company now expects that this component will not adversely impact Medicare reimbursement," Triad officials stated. ▼

'Framework' endorsed for health data exchange

Thirteen health and information technology organizations have endorsed what they say is a "common framework" to support health information exchange in the United States while protecting privacy.

The group presented David Brailer, MD, the national coordinator for health information technology, with recommendations for advancing the adoption of a national health information network that allows health care providers and patients to exchange health information to improve patient care.

The new environment, the organizations say, should be based on:

- open, consensus-driven and nonproprietary standards and common methods for their adoption;
- connectivity built on the Internet and other existing networks;
- uniform policies that protect privacy, assure security, and support existing trust relationships.

The collaborative also recommends the use of financial incentives for the adoption of standards-based information technology in health care.

Members of the group include the American Health Information Management Association, eHealth Initiative, Healthcare Information and Management Systems Society, and National Alliance for Health Information Technology. ▼

On-line resources' role increasing for seniors

On-line resources soon may play a much larger role in informing the nation's seniors about their health and health care options, according to a survey by the Kaiser Family Foundation.

While less than a third of seniors (65 and older) have gone on-line, more than two-thirds of people between 50 and 64 have done so, the national survey found. Just 21% of seniors have looked for health information on-line, compared with 53% of those between 50 and 64.

Similarly, the study found, 8% of seniors get "a lot" of health information on-line, compared with 24% of those between 50 and 64. Just 26% of seniors trust the Internet "a lot" or "some" to provide accurate health information, vs. 58% of people ages 50 to 64. Seniors rank the Internet fifth as a media source for health information; however, those 50 to 64 rank it first. ▼

COMING IN FUTURE MONTHS

- A look at the new Medicaid waivers
- More on training for the call center
- Are you ready for the HIPAA security rule?
- Tips for enhancing customer service
- More on effective denial management

Standardization can save industry $77.8 billion

An analysis published recently on the *Health Affairs* web site (www.healthaffairs.org) estimates that standardizing electronic health care information exchange and creating interoperable information systems could save the nation's health care system $77.8 billion a year.

The authors, from the Center for Information Technology Leadership at Partners HealthCare System in Boston, add, "We suspect that the clinical payoff in improved patient safety and quality of care could dwarf the financial benefits projected from our model, which are derived from redundancies that are avoided and administrative time saved."

David Brailer, MD, the national health information technology coordinator, and other experts present their perspectives on health information exchange in accompanying articles. ▼

Hospital consolidation not effective, study shows

A study published recently in the journal *Health Affairs* examines the impact on certain performance measures when a hospital consolidates into a health system, based on a sample of hospital consolidations in four states.

The study, conducted from 1999-2000, at the height of the hospital consolidation trend, concludes that the consolidations on average did not increase efficiency, quality, or charity care within one year, although health plans on average paid higher prices to hospitals in the system. ▼

Hospitals make the list of best places to work

Several hospitals were named to *Fortune* magazine's 2005 list of "100 Best Companies To Work For," including Griffin Hospital in Derby, CT, which was ranked the eighth-best company and third-best small company to work for in the United States.

The designation was based in part on the unique amenities the hospital offers its employees.

Other hospitals and health systems named include Baptist Health South Florida in Coral Gables (31 on the list); Bronson Health in Kalamazoo, MI (36); Memorial Health in Savannah, GA (48); Baptist Health Care in Pensacola, FL (59); and St. Luke's in Houston (69).

The annual ranking is based on an evaluation of the organization's culture and policies and a survey of its employees. ■