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APRIL 2005
VOL. 24, NO. 4 • (pages 37-48)

No detail too small as system prepared for POS collection

Multidisciplinary team led effort that began with CFO directive

When Palmetto Health in Columbia, SC, decided to launch a major point-of-service (POS) collection effort almost three years ago, commitment came from the top down, and preparation was extensive, says **Charlene Cathcart**, director of admissions and registration.

"We established a multidisciplinary team that included not only patient financial services and registration, but also the ancillary departments and the physician practices — everybody who touched patients or had an impact in some way, either on the front end or the back end," she says.

"We also included our public relations department, because we knew we eventually needed to get the word out throughout the [health system's] three hospitals," Cathcart explains.

"We needed everyone's buy-in and participation in the process. They needed to understand the impact on Palmetto Health of not doing POS collection and the benefits on the back end when you do," she continues.

It was important that staff throughout the three-hospital system, which has more than 1,200 total beds, knew the thinking behind the effort, Cathcart points out. They could then respond appropriately if patients said something like, "I can't believe those admitting people asked me for money!"

The cash collection project started at the request of the health system's chief financial officer, who heads a summit that oversees the organization's revenue cycle, notes **Rebecca Richardson**, CPA, CIA, director of management support services.

"As [the summit] worked through those issues, he saw that we were missing opportunities with POS collection, that we were not doing a good job of asking [for payment], that most employees didn't think to ask, and that there was a reluctance to ask because of fear of rejection," she adds.

Richardson, who works in corporate finance and reports directly to the CFO, originally facilitated the multidisciplinary team and also oversaw the creation of a standardized POS manual that includes "from beginning to end" the expectations associated with the collections effort.

One of the reasons for the manual, Richardson explains, is that while Cathcart has a protocol for teaching her employees, not everyone who registers patients reports to admissions and registration.

"In other areas, there is quite a variety of knowledge levels," she says.

"We needed a guide to set forth standards for the folks in radiology and in other ancillary areas. There also tends to be turnover in the [registration] role. The further we went [in writing the manual], the more we thought of something else to include," Richardson notes.

"We determined in the beginning that we couldn't ask people for money without making sure they understood the whole shooting match," Cathcart adds.

Among other things, she notes, the manual includes a letter from the CFO, policies and procedures for handling cash and getting receipts, frequently asked questions, and an explanation of all the forms that are used.

"Some people are very visual, so we flowcharted the entire process," Cathcart says. **(See Cash Receipts Handling, pp. 39-40.)**

Determining payments

Palmetto Health uses the electronic verification system, Real-Time Eligibility, (formerly called Medifax) that brings up the benefits data for some insurances. If registrars can find the exact amount a patient owes, that's what they try to collect, Cathcart explains.

In the areas in which immediate insurance verification isn't done, however, the health system asks patients for pre-defined deposits, she says.

To come up with the appropriate amount for those deposits, Palmetto ran three years' worth of payment data, by service, Cathcart adds.

"So we looked at three years of payments by patients who had heart catheterizations, for example, and determined on average what they owed," she says.

If the figure is high or low, it is adjusted later, but because the health system was very conservative in setting the amounts, Richardson notes, "we found that we were not writing a lot of refunds."

If a Medicare patient comes in for a screening mammogram, the amount to be collected is $11.72, while the amount for a gastrointestinal procedure is $100, Cathcart says.

"We tried to make it pretty simple for registration staff. If the patient has South Carolina Medicaid, which doesn't require a copay for all services, we identified the services for which it does require one," she says.

Patients without insurance are asked to pay the same amount as those who are insured, adds

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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), $199. 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.)

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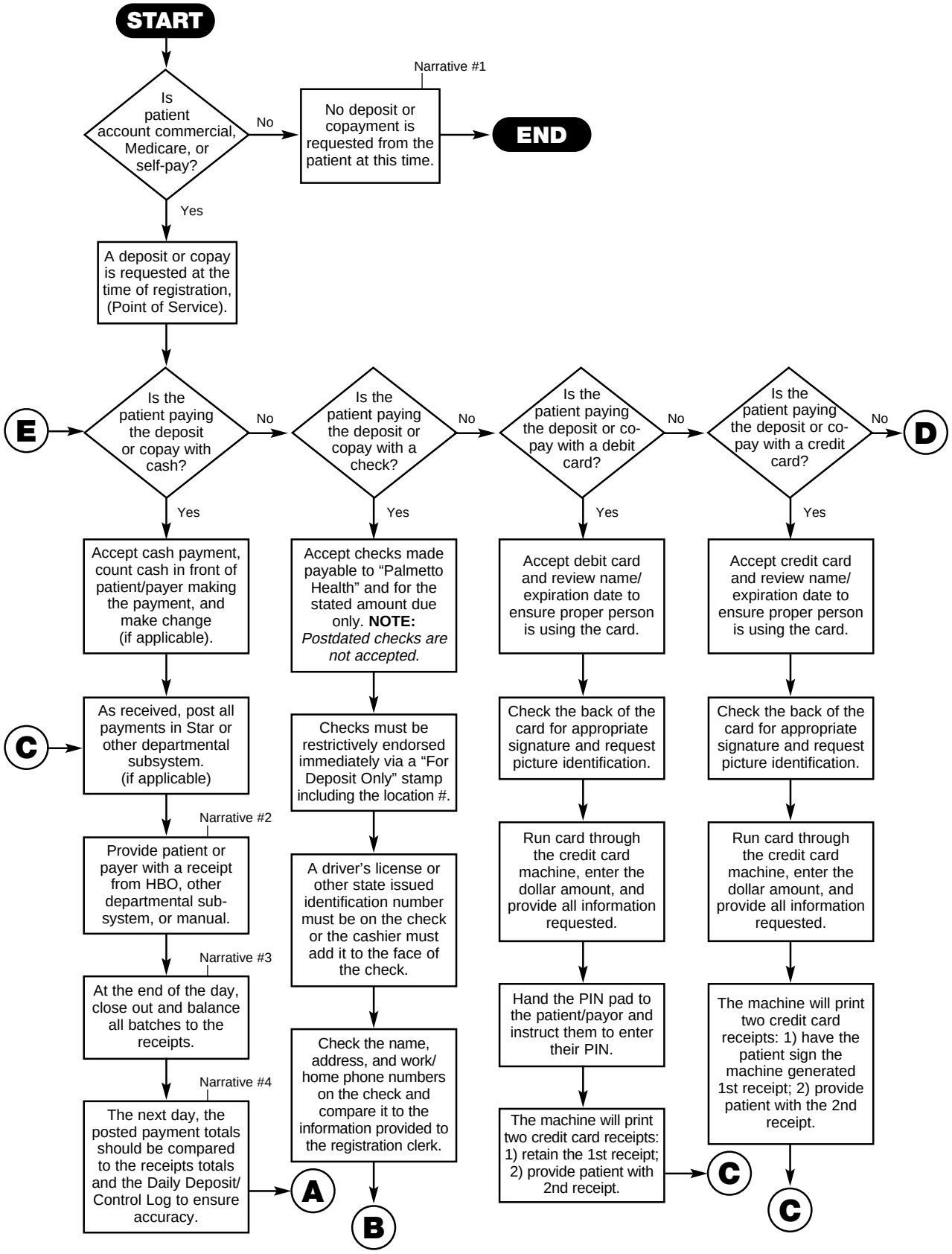
Cash Receipts Handling



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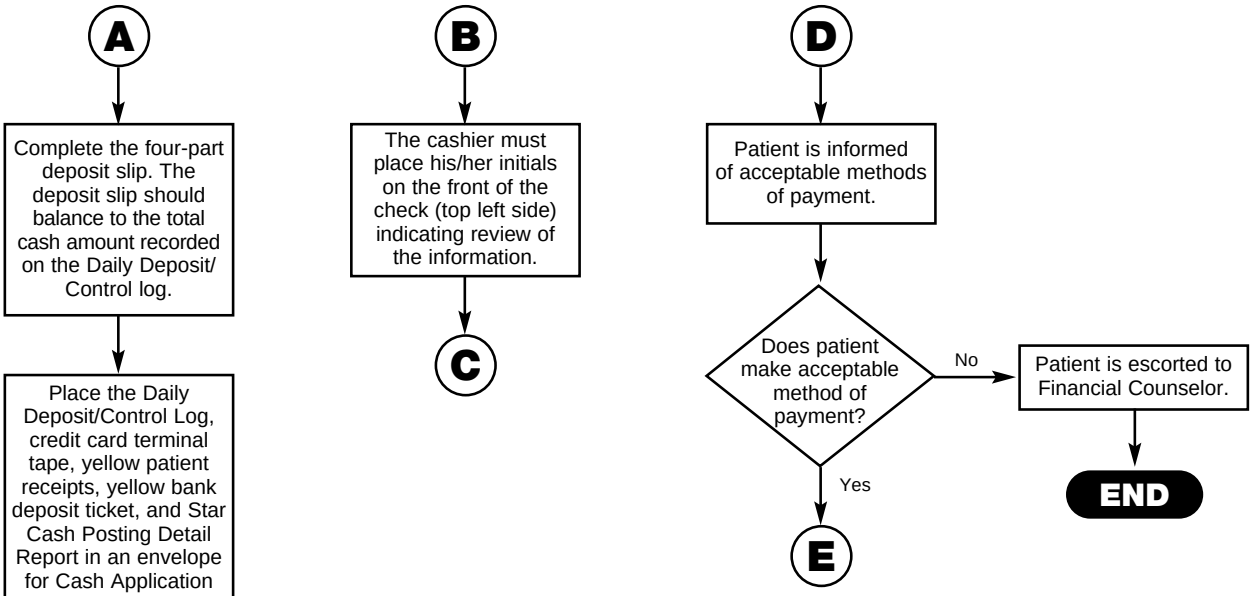
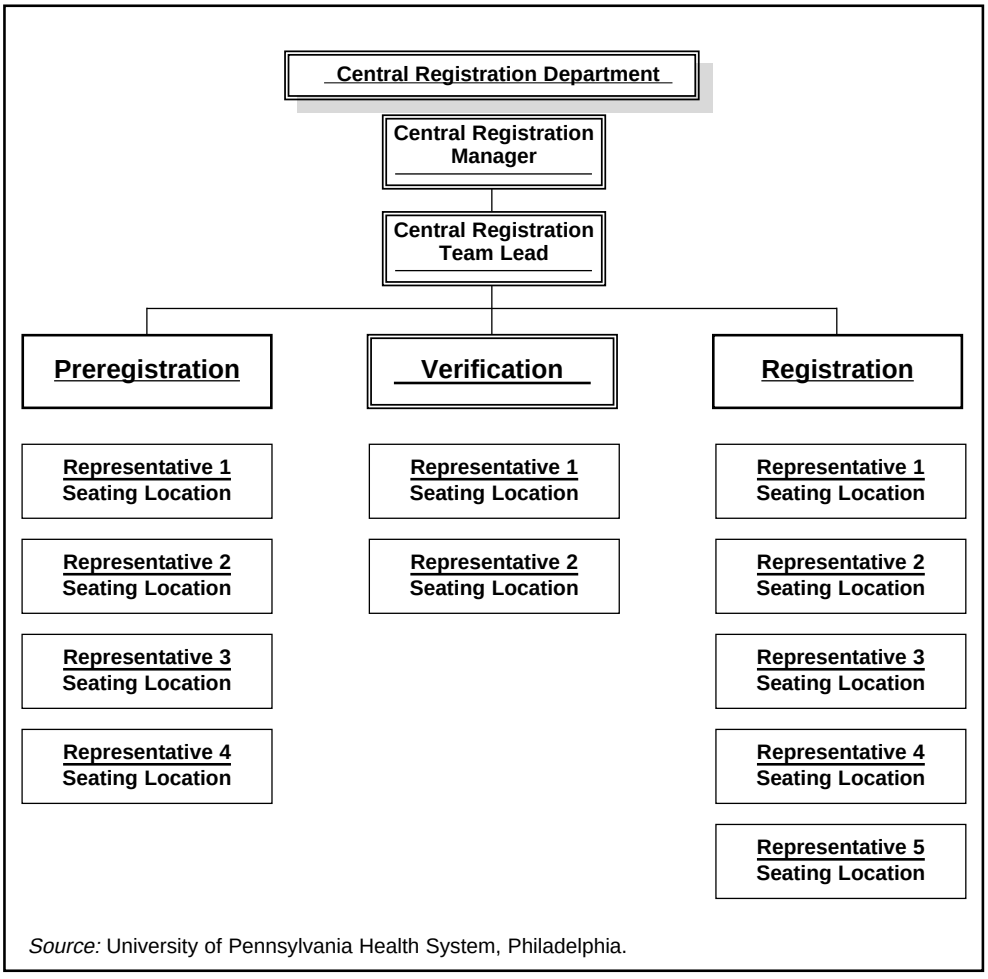


Source: Palmetto Health, Columbia, SC.

Cash Central Flowchart



Source: University of Pennsylvania Health System, Philadelphia.

(Continued from page 38)

Richardson. "Care is often perceived as free, and part of the strategy is to help educate the community. [Asking for payment] is a way to start the conversation."

No detail was too small when it came to facilitating the process, Cathcart notes.

In addition to teaching registrars how to operate credit card machines, she says, management had the machines standardized throughout the health system. This enabled them to reduce fees and to make it easier for registrars to work in different areas. It also made sure the machines could take all major credit and debit cards, which they couldn't do before.

While staff were being shown the fine points of counting cash in front of patients, writing receipts, and expressing thanks for the payment, it was decided that receipts and other paperwork should be the same color at all three hospitals, she continues.

"For example, if we were going to give the patient the white copy of the receipt, keep the pink copy, and send the yellow copy to accounting," Cathcart says, "we kept that concept with the daily control log and even with the deposit slips. We wanted people to think, 'This is yellow — it goes here.'"

Comprehensive education effort

The education provided to help registrars feel competent and comfortable in all areas of POS collection was detailed and comprehensive, she notes, and included everything from standard scripting for conversations with patients to role-playing to presentations by outside experts in the field. **(See article, at right.)**

Physicians were sent letters informing them about the collection initiative, Cathcart says, and the entire hospital was targeted with a six-week campaign called "Remember Bill." Signs posted throughout the facility described a famous person named Bill, and people were encouraged to guess who the person was, she explains.

"A key point that we wanted people to understand [about the collections program] was at the bottom of the signs each week," Cathcart says.

"For example, we put that there was a cost savings on the back end if we didn't have to send bills. To get people to read that, we had them try to figure out if the person described on the sign was Wild Bill Hickok or Bill Cosby," she adds.

Every other week for six weeks, people would submit the answers to try to win a prize, and three winners were drawn from the entries with the correct answer. Meanwhile, "we got across six key points." Cathcart explains.

The key to the success of the initiative, which resulted in a 30% increase in collections the first year and a 40% increase the next, is communication, Richardson notes.

Her advice to those embarking on such a program is to make sure there is buy-in from senior management and to set patient expectations as early in the process as possible. Palmetto Health, for example, put letters explaining the collections effort in the surgical packages patients receive from physicians.

As part of her initial oversight of the project, Richardson explains, she arranged for signs in English and Spanish to be placed at each registration location.

"We also [have staff] discuss it in the scheduling process, and we accept payment by credit card during the preregistration phone call," she says.

"It's the perfect place to bring it up. Some were dubious when we put [a credit card machine] in that area, but we have had some success with that." Richardson adds.

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Extensive POS education preceded collections push

Registrars coached on 'how to ask'

Palmetto Health employed a multifaceted approach to educating registrars when the Columbia, SC-based organization undertook an ambitious point-of-service (POS) collection project in 2002.

In addition to creating a comprehensive POS manual, explains **Charlene Cathcart**, director of admissions and registration, Palmetto designed two POS collections classes — one focused on such details as using a credit card machine, writing receipts, and balancing out at the end of the day, and another aimed at teaching registration employees how to request payment.

Getting employees to feel comfortable asking patients for money proved to be a challenge, she adds.

"We actually tried for probably a year and a half on our own to teach people how to ask," Cathcart notes.

"In June 2004, we decided to bring someone in from the outside to try to get those collectors who needed help and people who were not comfortable with the whole process into a different kind of training," she adds.

Following a recommendation by a member of the multidisciplinary team overseeing the collections project, and with the assistance of the organization's education department, she says, management engaged the Dallas-based Medical Business Institute (MBI) to join the effort.

An educational consultant with MBI did two three-hour sessions in one day, with 95 employees participating, Cathcart continues. "She did the training from the standpoint of, 'You've got to make people pay.' [As a result,] our collectors who were afraid to even ask were able to come to a happy medium."

That session "was a real turning point," adds **Rebecca Richardson**, CPA, CIA, director of management support services, who helped oversee the POS project.

"[The trainer] legitimized asking for money — that it is something you need to do for your organization, and that it's becoming common industrywide," she adds.

"We learned a lot from that session on how to get people to the next level," Cathcart adds. "Something clicked for the supervisors who work at the access points. They realized that the best way to role-play is to put the weakest collectors with the strongest ones, and let one be the patient and one the collector, and then switch roles."

She also created a list of dos and don'ts to remember when educating staff. For example, Cathcart advises against underscoring the importance of collecting payments up front by talking about the time value of money.

"Most people don't understand that because it's not real to them," she suggests. "Do talk to the staff about the cost of billing the patient vs. collecting on the front end. It's pretty easy to come up with a dollar figure. The woman who spoke at our education session said it costs about $9 to bill a patient."

As part of their training, registrars took a competency quiz to determine how well they could read and understand insurance benefits, Cathcart adds. As part of the test, they were given a list of benefits and treatment information for fictitious patients and asked to calculate how much their payment should be.

While designing the cash collection program, Cathcart says she has come up with a list of pitfalls and obstacles that can sabotage the effort:

- **Lack of knowledge and education about POS collection**

  Identify all those who touch the process — patient, physician, ancillary department personnel, guest services, customer relations, and senior management — and determine the best way to communicate the necessary information, she suggests. Physicians, for example, were sent a letter from the CFO explaining the program, while other groups received training.
- **Expectations not set**

  To avoid this pitfall, Cathcart says, Palmetto Health put up signs in collection areas and inserted notices in surgical packets.
- **Staff fear of resistance**

  Having registrars role-play with more seasoned collectors, bringing in the MBI consultant to conduct classes, and discussing the program in staff meetings was Palmetto's solution. In addition, she recommends posting collection results and recognizing outstanding collection efforts.
- **Not knowing what to collect**

  Cathcart suggests developing pre-defined deposits for each area or providing extensive education on how to read and understand insurance benefits. "Any time we know what a particular insurance will pay, we ask for that amount." In South Carolina, she adds, a state employee has to pay $75 for each hospital visit, but the insurance card may or may not state that.
- **Lack of standardization of entering insurance benefits**

  An initial problem for Palmetto Health's program, Cathcart notes, was that when registrars called to verify insurance benefits, they would record the information as the insurance company gave it, which resulted in data being in different order, and would sometimes abbreviate strangely.

  To remedy that, Cathcart preset the order and content of the data, and using the insurance user-defined fields in the computer program, set up questions that, whenever possible, had a "yes" or "no" answer. "If it was something having to do with money, we had the computer convert it to currency, so the [registrar] didn't have to worry if a number was a percentage or a dollar amount," she says.

- **Lack of clear policies and procedures**

Be aware that policies and procedures could be written in a way that is hard for the average person to understand, Cathcart suggests. "Use routine language.

"Make sure they're accessible," she adds. "We put them on the hospital's intranet web site. All of the staff have access to the intranet, so they can click on that manual any time they have a question, and we didn't have the cost of printing 200 or so manuals." ■

3-team outpatient process generates quick payoff

Registration flow is unimpeded

When the University of Pennsylvania Medical Center-Presbyterian in Philadelphia transformed its outpatient registration staff into three teams, each with a specific task, the benefits were apparent immediately, says **Raina Harrell**, business administrator for patient access.

What existed before, she explains, was a typical outpatient registration area that handled scheduled and nonscheduled registrations, called for referrals and pre-certification if needed, and sent people to the appropriate areas to have their services.

"What was happening, is that [staff] didn't always know when a pre-cert was required, and we were getting a small percentage — less than half — of accounts preregistered," she notes.

"So we had patients coming in for high-dollar MRIs [magnetic resonance imaging] and CAT [computerized axial tomography] scans, and they were not preregistered for services," Harrell adds.

Registrars who are busy dealing with the flow of patients sometimes allowed the authorization calls to slip through the cracks. If they did interrupt the registration process to make a pre-cert call or obtain a referral, waiting times often increased, she adds.

Attacking the problem

Although the hospital did not track outpatient denials, Harrell says, "we knew our outpatient accounts receivable [AR] days were very high, so we wanted to reduce [that number]."

With an eye on reducing outpatient AR days by boosting the number of preregistered accounts and making sure they are 100% secured, Presbyterian divided the 12 outpatient registrars into three groups, as follows.

1. **Preregistration team:** These four employees are focused solely on calling patients and getting them preregistered for services, with the objective of working five business days out.
2. **Registration team:** These five employees only take walk-in patients, those who come in for an unscheduled laboratory and radiology procedure.
3. **Verification team:** These three employees take care of pre-certification and verification issues for preregistered patients and check the insurance for every walk-in patient to see if a pre-cert, copay, or referral is required.

"We now have verification in the middle [of the process]," Harrell says, "and we've also put a verifier with the registrars. If anyone walks in and their insurance requires a referral they don't have or additional documentation, the verifier can make the phone calls so the registrar does not have to slow down the process."

The reason the registration team has more employees is that in some of the ancillary areas covered by outpatient registration, the registrars perform both registration and preregistration functions, she explains.

Success was immediate

When the hospital went live with the new process in mid-February 2005, it was a success from Day One, Harrell says.

"It went marvelously. We had extra management on hand in case [team members] didn't know what the next step should be — they were so used to doing it all — but [the team members] didn't need the assistance," she explains.

Patients experienced waits of only between 7.5 and 12 minutes during most of that first day, she explains, and when the process slowed down a bit at lunchtime, the longest anyone had to wait was 20 minutes. In the past, waits during busy times could average between 23 and 28 minutes, Harrell adds.

The outpatient employees, most of whom have been on the job five, 10, or 15 years, are happy with the new system, partly because "there had never before been this much of an overhaul without staff reduction," she notes.

Employees also were delighted to have played a part in the design process, Harrell continues.

"Management did the model, but we let [the employees] work out the details of the flow of information," she explains. "They were involved in the weekly meetings that we've implemented to talk about the process [and] any glitches we might run into."

Weekly meetings regarding the process are ongoing, Harrell says. "On Tuesdays, I meet with the outpatient manager and supervisor and the departmental manager for quality and training to talk about the previous week — the statistics and the areas for improvement."

Outpatient staff divide into two groups and attend Wednesday meetings where managers go over the past week's results with them and talk about training initiatives, she adds. "We keep these meetings to a half-hour, so they move quickly."

Working through the process

Harrell, with the help of Portland, OR-based revenue management consulting firm Stockamp & Associates, is in the process of designing a statistical report that will provide data on how many patients come in, the percentage of scheduled vs. unscheduled patients, how many accounts were pre-verified, and so on, she adds.

In fact, she explains, Stockamp facilitated the entire process of moving to the three-team model — doing flowcharts, organizing meetings, and helping hospital staff work through the different steps. **(See Cash Central Flowchart, p. 40.)**

"We were using [the company] in inpatient insurance verification and the business office with revenue-cycle improvement functions," Harrell says. "They have a tool — a work driver — that takes a download from our billing system and prioritizes and distributes the work to our inpatient verification team.

"Normally, Stockamp doesn't go into the outpatient area, but we asked them to assist us there," she adds. "We did the design, and they helped us implement it. Using their knowledge, we did a homegrown version of [the work driver], with reports from our computer system."

The statistical report, meanwhile, will assist in holding team members accountable for how they perform, Harrell notes.

"There are expectations — for example, a certain number of preregistrations that have to happen per hour," she says.

Drawing an example from the inpatient side, an inpatient team member might be expected to enter 50 reservations from a physician's office in a day. If the person does 40, the number will be "4," which is added to a number indicating whether the person met the expected accuracy level of 95%, adds Harrell.

While the departmental trainer still is determining what that number will be for the outpatient team, the system will work much as it does in the inpatient area, where each team member gets a number indicating the quality of their work and another representing quantity, she says. "We'll put those together to get each person's [score] for the week."

Harrell says she is pleased with the outpatient redesign and anticipates further improvement. "This is just the beginning of the project. We are looking forward to even more positive results."

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HIPAA requests increase as patients gain savvy

Education crucial, consultant says

Although few patients have taken advantage of the Health Information Portability and Accountability Act (HIPAA) privacy rule that allows them to amend their medical records, those numbers will increase dramatically as people gain confidence in owning their health care data, predicts **Caroline Stuart**, MA, RHIT, a management consultant with the Dearborn, MI-based health information management division of ACS Health Care Solutions.

"Patients are just now realizing that they can demand corrections to their medical record when they have been charged for services, tests, or levels of care they did not receive," Stuart notes.

Staff should become HIPAA experts

With that in mind, she emphasizes, health care providers must make HIPAA-related education a priority. "The more we educate staff, the more patients will be educated. What I'm seeing is that [this] has not happened."

In the future, Stuart adds, amendment requests

will increase "and all staff will become HIPAA experts."

After all, she points out, one of the goals of HIPAA was to educate individuals to take more responsibility for their own health care and to ensure their right to privacy and control of their personal health information.

Anticipation of the "many, many revisions" to patient records that will have to be accounted for in the future is behind the recent push by the American Hospital Association (AHA) and nine other health care organizations for the exemption of all mandatory and routine disclosures to government entities from the privacy rule's accounting of disclosures requirement, Stuart suggests.

In mid-February 2005, those organizations urged the Department of Health and Human Services (HHS) to take immediate steps to modify the HIPAA privacy rule to that effect. In a letter to HHS secretary Mike Leavitt, the coalition organizations note that the Government Accountability Office also recommended exempting such disclosures from the rule in a report in September 2004.

That report expressed concern that the requirement to track and account for such disclosures did not support the rule's goal of ensuring effective patient privacy protections without imposing unnecessary costs or barriers.

In her experience to date, there have been few formal HIPAA amendments to records by patients, Stuart says. "The health care industry is aware that the volume of patient requests to amend and control health care data will rise as patients become better educated."

During implementation of the HIPAA privacy regulations, which became effective April 14, 2003, she recalls, the primary concern of the health care organizations with which she worked was not education, but rather the purchase of technology to track the trail of requests for patient information should anyone ask for it.

"The problems that are arising today, post-HIPAA, are linked to facilities having the capability of merging revisions into electronic health records," Stuart notes. "Additionally, facilities are perplexed at potential problems that may arise in the submission of amendment data to fiscal agencies that could potentially delay the billing and revenue processes."

AHA and other organizations are concerned that the accompanying documentation will further clog information systems that already are jammed as patients begin to question whether they have been charged for a treatment or procedure they never received or disagree with a physician's diagnosis because it could cause job-related problems, she says.

"If a patient goes in and asks, 'Who did you release my record to, and which part did you release?' and adds, 'I don't want my employer to know that I had treatment for hepatitis C, which could affect my promotion,'" Stuart points out, the resulting demands on the provider can be staggering. "Everybody has to keep a list [of sources of electronic data]."

Up until now, she says, "hospital management has been HIPAA-trained, but hospital staff have been just barely educated. If a patient asks an admitting representative to explain what the HIPAA clause in a consent form means," Stuart adds, it's not likely he or she will get an adequate answer.

The staff knowledge level is improving, however, she says, noting that it is normal for full implementation of such a process to take a decade or more. "This is to be expected."

Stuart says she personally is looking forward to the future paperless documentation of health care data. "I have confidence that billing and reimbursement technology will advance in tandem to meet patient demands for amendment and disclosure." ■

Survey: HIPAA security compliance not imminent

Numbers declined in recent months

As this month's Health Information Portability and Accountability Act (HIPAA) security rule deadline arrives, overall compliance with the rule does not appear imminent, judging from a recent survey by the Chicago-based Healthcare Information and Management Systems Society.

April 20, 2005, is the compliance deadline, but only 74% of health care providers anticipated being ready by that date when questioned for the survey, which was co-sponsored by Phoenix Health Systems, a nationwide health care information management firm based in Montgomery Village, MD.

Only 18% of providers indicated they were currently compliant with the security rule when questioned for the U.S. Healthcare Industry HIPAA Compliance Winter 2005 Survey, the

results of which were released in mid-February. The same percentage reported readiness when surveyed in June 2004.

Thirty percent of payers said they were compliant with the security regulations in the most recent survey, up from 13% in June.

The total number of organizations that were not yet compliant but expected to achieve compliance on or before the deadline actually declined in the six months prior to the survey: 40% of providers and 26% of payers said they had experienced at least one data security breach since June 2004, according to the survey.

While 87% of providers in summer 2004 anticipated compliance by the deadline, only 74% predicted in the winter 2005 survey they would be compliant by then. The percentage of payers predicting compliance by the deadline declined from 91% in summer 2004 to 80% in the winter 2005 survey.

However, the survey results did indicate organizations were making progress in two key areas of security rule compliance:

- 93% of providers and 98% of payers had designated an individual as the security officer/official.
- 32% of provider organizations had conducted required HIPAA security training, with an additional 60% expecting to finish before the deadline.
- 37% of payer organizations had conducted the required training, with another 58% expecting to finish before the deadline.

Also, as part of the survey, providers and payers were asked to indicate all security standards they found difficult to implement, and differed only slightly in their assessments.

The following reflect the percentage of each group that checked the noted item as one of the standards they found difficult to implement:

Providers

- Audit controls (55%)
- Risk management/risk analysis (49%)
- Information system activity review (48%)
- Data backup plan/disaster recovery plan/emergency mode operation plan (39%)

Payers

- Information system activity review (40%)
- Risk management/risk analysis (34%)
- Audit controls (32%)
- Data backup plan/disaster recovery plan/emergency mode operation plan (29%)

Privacy compliance not complete

Asked about their status regarding the HIPAA privacy standard, 78% of providers and 90% of payers said they are compliant with the privacy rule, almost two years after the April 2003 deadline. Sixteen percent of providers and 8% of payers reported that they remain noncompliant, which reflects little or no improvement since the June 2004 survey.

Even among compliant organizations, gaps remain in certain areas, such as establishing business associate agreements and monitoring internal privacy compliance, the survey found.

Seventy-three percent of providers and 56% of payers reported their organizations had experienced one or more privacy breaches over the past six months. Additionally, the survey revealed that 27% of providers and 31% of payers have had at least one formal complaint of privacy violation against them, either with the federal government or in a civil proceeding, since the compliance deadline.

Progress toward compliance with the HIPAA transactions and code set (TCS) standard was

made in the six months between the surveys, the sponsors reported, with 73% of providers and 70% of payers indicating compliance, up from 65% and 62%, respectively.

In other survey data concerning the TCS standard:

- 90% of providers are transmitting at least one of the HIPAA standard transactions to their payers; 70% of providers are transmitting more than half of the transactions, and 49% are transmitting all of them.
- 56% of payers are capable of conducting all of the HIPAA standard transactions.
- 47% of providers and 62% of payers indicated there are transactions that their information systems are capable of producing, but that are not being conducted at this time, in part due to the inability of their trading partners to accept or transmit them.
- 48% of providers and 65% of payers are taking advantage of the Centers for Medicare & Medicaid Services contingency plan. However, the percentage of organizations that support continuance of the plan is declining. ■

End-of-life issues may be most difficult for DP staff

Religious, cultural beliefs may affect plan

At Medical City Dallas Hospital, staff tailor their discharge planning and education around the patient and family's cultural beliefs, particularly when end-of-life issues are involved.

The hospital treats a significant number of Hispanic patients along with increasing numbers of Asian and Russian patients, says **Pat Wilson**, RN, BSN, manager of case management.

"The strongest and hardest obstacle we have to overcome with our patients from diverse cultures is death and dying," she explains.

For instance, many Hispanic families reject hospice care for terminally ill patients because they feel as though it is giving up, Wilson says.

"In these cases, we work more toward teaching the family how to care for those going home with an end-of-life disease. The physicians and other staff are very careful with their wording so the hospital can provide the palliative care the patient needs without creating the impression that it's hospice care," she says.

Most Hispanic patients have very strong family ties and have caregivers at home who are willing and able to do whatever is necessary to provide care for the patient, rather than hiring someone else to provide care or considering a skilled nursing facility, Wilson adds.

When this is the case, lot of time is spent educating the family members about how to care for the patients at home, the medications they need, and when they should receive them.

The hospital works closely with home care agencies that have Hispanic caregivers so the patient and family will feel comfortable with at-home care.

The hospital staff have learned to pick up cues from family members about the direction they should take in caring for the family members.

When they are assigned a patient from another culture, staff identify a family member who is the spokesperson and, with the help of an interpreter, gives him or her the discharge instructions.

Staff typically use both a medical translator and a family member to make sure what they are saying is being translated correctly. They ask the family member translator to repeat what they understood.

"The staff do an excellent job of identifying a person in the family who can be the spokesperson and can help us understand the cultural beliefs and how to address them," Wilson says.

For instance, many elderly patients have grandchildren who have become Americanized and are a great resource for helping staff understand what medical care is like in the family's country of origin as well as its cultural practices and beliefs surrounding health care.

Staff enlist the aid of the grandchild to compare what would be happening if the patient were in his or her native country with what is going on in the hospital.

"We discuss what our traditional treatment plan is here and ask them to help us determine what will work best for the grandparent. We want to incorporate the family's cultural beliefs whenever possible, as long as it isn't anything that will interfere with healing," she notes.

When staff members have trouble accepting that their patients' cultural beliefs don't allow certain medical procedures that are routine in Western medicine, Wilson and other department heads refer them to the hospital's ethics committee to help them work through the issues.

"They may think the treatment that has been proposed will be beneficial to the patient. If the family says they don't want the treatment and the staff truly believe it is beneficial, that's an ethical conflict between the health care worker and the family," she says.

The ethics committee does not make any decisions in these cases but can help the health care workers resolve the issues for themselves, Wilson points out.

Staff at Medical City Dallas attend annual diversity seminars designed to help them understand the cultural beliefs and practices of the hospital's diverse patient population.

The hospital's diversity program gives staff basic information about patients from other cultures, tips on contacting appropriate health lines and community organizations, and instruction on how to use the translator line.

"We give our staff a good overall view of the cultures we see in our hospital, their values, beliefs, and practices, and how we can respect them and provide the best treatment for our patients," Wilson explains.

The hospital has translated its discharge instructions and other pertinent documents into Spanish. The hospital maintains a list of bilingual staff members who can be called on to help the rest of the staff build bridges with the patients.

For instance, one staff member is from Iran and speaks Farsi. There are several Spanish-speaking social workers. They are called by their co-workers and other people in the hospital to translate.

"When we're talking about the Asian community, it's harder to find staff who can communicate with them. We do have some physicians who speak Chinese or Vietnamese or Korean, but we also tend to use the translator line," she says.

The hospital has established a mentoring program that pairs new hires with nurses from their same country who act as mentors.

"It not only gives them a bond with someone who shares their background, but it gives them a mentor to help them learn about the hospital. It's one of the best things we've done to acknowledge and respect different cultures and to recognize that there is a difference and that we need them," she adds.

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