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IN THIS ISSUE

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Patients give hospital heads-up: It's time for on-line registration

Screen flow, 'guided accuracy' important

It became very clear that customers of Dayton, OH-based Kettering Medical Center Network (KMCN) were ready for on-line registration soon after the hospital network began testing the process in August 2004, says **Grace Curtis**, MBA, director of patient registration and central scheduling.

"We started looking at [on-line registration] at the beginning of 2004, and by August, had developed some screens and were pretty far along," she notes. "We did two months of testing and then found we had to go ahead and roll it out in January 2005."

What happened was that although there was no direct link, people using the search box on the KMCN web site found the test version of the on-line registration form and began filling it out and sending it in, even though the service hadn't yet been offered to the public, Curtis explains. "We realized that there was an expectation on the part of consumers that you do business electronically," she says. KMCN still hasn't promoted the service and is averaging 2.5 on-line registrations a day.

"We had some coverage from local news journals," Curtis adds, and the central scheduling department includes information on on-line registration in the packets that it sends out to patients.

To further spread the word, she says, brochures describing the on-line registration option will be placed in physician waiting rooms.

Although on-line forms, at present, represent only a small fraction of the 500,000 registrations done annually by KMCN's four hospitals and numerous clinic sites, Curtis says, the organization sees the potential for much more business being done that way.

"I think our next route is that we want to set up secured accounts with people, so they can go in, review the [registration] information, and eventually begin to look at their account information," she says.

Curtis' advice to those toying with the idea of on-line registration is "to just begin to do it, to take the step. It's a much easier process than one would think."

At present, the KMCN registrations received on-line are not directed straight to the admission/discharge/transfer (ADT) system, she explains. "They're printed off, and a designated registrar creates all of those registrations for the entire network.

"The real problem is that if you drive them directly into the [ADT] system, you have no human intervention to let you know if you're creating a duplicate account," Curtis says. **(See flowcharts showing on-line registration process, pp. 99 and 100.)**

KMCN is transitioning to a new version of its ADT system and as part of that process may — somewhere down the line — work with the information technology department to create a temporary account whereby on-line registrations could be received and verified, Curtis notes.

They might be automatically matched against a master person index, for example, without having to be manually entered into the system, she adds.

"If we go to a secure account where we really know who we're dealing with, we'll be a lot more competent in creating an account from the on-line system," Curtis says.

That process would require that consumers use a password to log in and create an account for themselves, or perhaps verify the information the system already has for them, she explains. "The person might look at the information and say, 'Oh, I have a new phone number,' and make that change."

Still, Curtis recommends that whatever the ultimate technology plan, hospitals take the interim step of having the on-line registrations go into a temporary holding pattern. "You will learn a lot about it. It's well worth it, even if you are re-keying the data."

The advantage there, adds **Jana Mixon**, patient access manager for Kettering Memorial and Sycamore, two KMCN hospitals, "is the ability to control the information that is being entered. It won't be compromised by a patient not understanding what we're looking for or by putting in a wrong number."

Getting the bugs out

KMCN continues to tweak the on-line registration process, Curtis notes. "We learn along the way and make changes constantly. One [enhancement] is that we just got the system to send [the person registering] an automatic confirmation that the information was received. That cut down on the number of people calling to check."

A toll-free number is available 24/7 for those who have questions, she adds.

Screen flow was an important consideration in the design of the on-line registration process, Mixon adds. "I went through the registration process as it stands in the [ADT] system and laid out the [on-line] screen flows to exactly match the order and the information we're asking for," she says. "It's really important to follow that flow. By doing that, when we get the information out of the server, it's easy to go right down the line and

(Continued on page 100)

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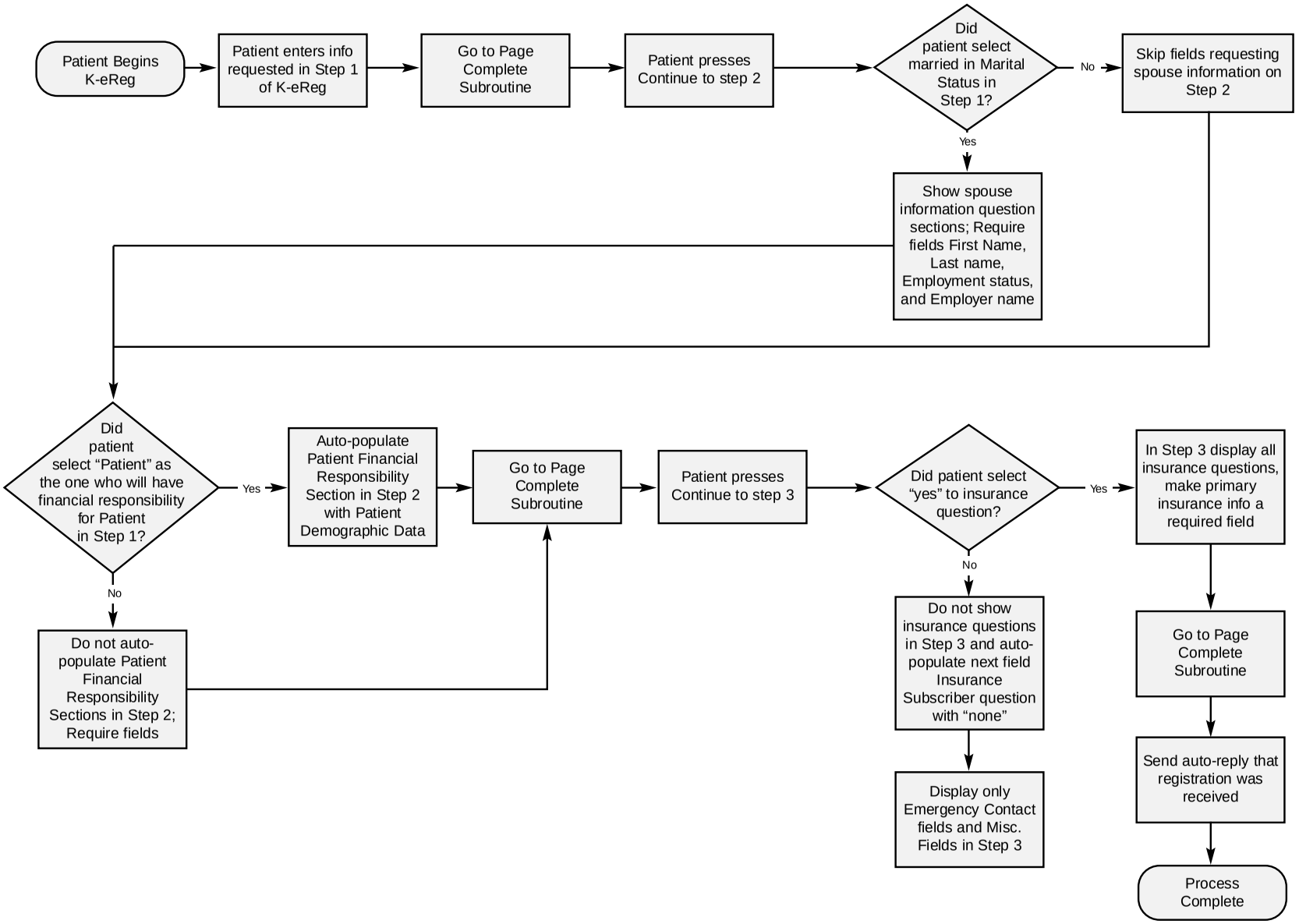
K-eReg Flow by Step



Source: Copyright 2005. Kettering Medical Center Network. Web site: www.kmcnetwork.org/index.html.

key in the information."

Because the on-line screen flow matches that of the face-to-face registration process, it takes just a few minutes for the designated registrar to enter the data, "and if the patient has been here before, it's just a matter of verification," Curtis explains.

To further smooth the on-line registration process, KMCN uses something known in the industry, creating on-line forms as "guided accuracy," she says. That means, for example, that if a person answers yes to the question of whether he or she is married, the next question will be about the person's spouse, Curtis notes.

If the answer to the marriage question is no, "that next question doesn't even come up," she adds. "We looked at a lot of on-line registration systems that go straight down a page, but with ours, each page is customized depending on how you answered on the previous page."

In addition to emphasizing the effectiveness of guided accuracy, Curtis cautions those involved in creating on-line forms against using health care jargon.

The word "guarantor," for example — meaning the person who will be responsible for the bill after insurance has paid its share — is a term the typical consumer doesn't really understand, she says, so it isn't used anywhere on the form.

The KMCN system uses what she calls "fly-by" help to define other words or phrases the person may not be familiar with. "If you run a cursor over the word, the system will define it for you. The more you can do that, the better off you will be in terms of people not calling you with questions," Curtis adds.

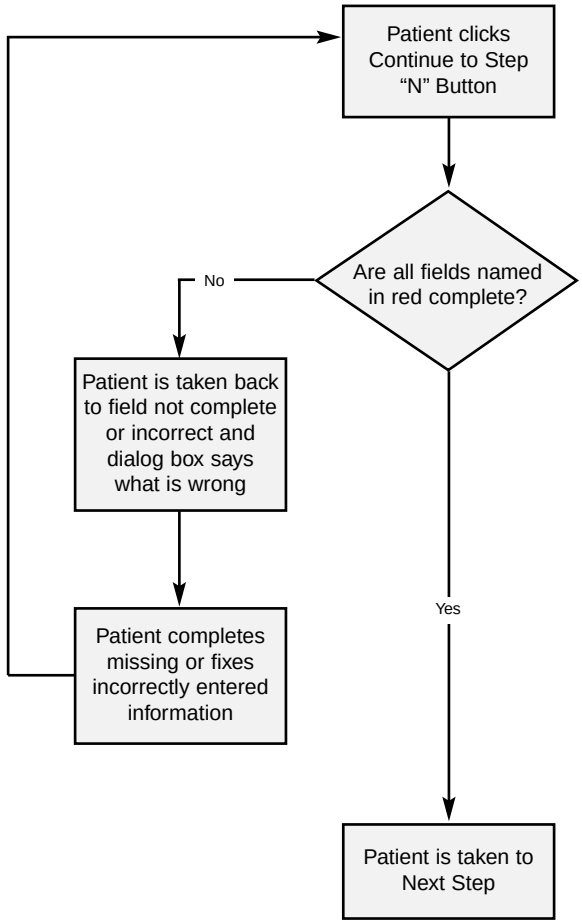
While the on-line registration service has the potential to create financial savings and reduce staff workload at the KMCN hospitals, Curtis emphasizes that the process was not set up for that reason. "The rationale is you want to give your patients as many access points as possible."

Another benefit she cites is that patients are more likely to provide complete and accurate information at home than at the hospital.

"When we send out packets with preregistration forms for patients who are scheduled for surgery, those forms come back with data that are very clear," Curtis points out. "We thought we'd get some of that same advantage with on-line registration."

Also, when patients provide information in advance — in any setting, including via on-line registration — KMCN uses an on-line verification tool, notes Mixon. "We are able to know very

Page Complete Subroutine



Source: Copyright 2005. Kettering Medical Center Network. Web site: www.kmcnetwork.org/index.html.

On-Line Registration System

Goals of on-line registration

- ✔ Increase patient satisfaction
- ✔ Manage increasing volume
- ✔ Receive demographic data sooner and verify
- ✔ Cleaner preregistration — created in the quiet and comfort of the patient's home or office

Registration facts

- ✔ Typical on-line registrant: pregnant, Caucasian female, between 21 and 35 years old from a south Dayton suburb
- ✔ 73% are female
- ✔ From more affluent suburbs
- ✔ Age range of respondents:
  - birth to 20 = 4%
  - 21 to 35 = 38%
  - 36 to 50 = 27%
  - 51 and older = 32%

Source: Copyright 2005. Kettering Medical Center Network. Web site: www.kmcnetwork.org/index.html.

quickly, nine times out of 10, whether their insurance is valid."

In some cases, that tool also provides the person's out-of-pocket financial responsibility, she adds. "We have not yet started asking for copays upfront, but that is a long-term goal. **(For more goals, see box, p. 100.)**

"Anything we can get done in advance is a help," Mixon says, noting that offering the on-line registration option "has been a greater advantage than I thought it would be. It's made a difference with a lot of patients out there who are computer-savvy and who can do this rather than have to come in and sit and wait."

[Editor's note: Grace Curtis can be reached at (937) 298-4331.] ■

Publicity and planning drives on-line reg success

OB patients are biggest users

Marketing and advance planning were the keys to success when Memphis, TN-based Baptist Memorial Health Care began offering its patients on-line registration, says **Liz Tucker**, corporate director of access operations.

"We started by marketing [the service] in the newspaper, and then determined we would need to get [the information] into the physicians' offices," she adds. Research already had determined that those most interested in registering on-line were the labor and delivery patients.

"The marketing we did was for everybody, but we have found that [obstetrics patients] are the big user population," Tucker notes. "One of the most successful things we did was to have some table tents and appointment cards made up and placed in the physician offices. On the back of the cards giving the appointment [time] was information on how to register on-line."

Refrigerator magnets describing the on-line registration process, distributed at a health fair, were another important tool, she says.

The pilot project began in December 2003 at Baptist Memorial Hospital for Women. The five additional metropolitan Memphis hospitals started the service in February 2004, and by April 2004, all 17 Baptist Memorial hospitals were involved, Tucker explains.

The planning, however, began in July 2003, she points out, and included such steps as designing the web site link (www.bmhcc.org/facilities/preregister.asp), determining how users would maneuver through the site, and creating a logo for "epatient," as the on-line service has been named.

As with Dayton, OH-based Kettering Medical Center Network **(see cover story)**, Baptist Memorial's patients let the organization know it was time to offer on-line registration, Tucker notes. "The feedback we got on patient satisfaction forms was, 'Why don't you have this? We'd like to be able to access information on-line.'"

At its larger hospitals, she estimates, Baptist Memorial is receiving about 30 registrations per week on-line. "It's not to the level we'd like it to be," Tucker adds, but she notes that people using the service may be those who otherwise would have been difficult for preregistration staff to reach.

The advantage for staff is the reduction in time spent making phone calls, she says. "In the past, we would have to call them, get all the demographic information, and then call back after insurance verification. Now that is reduced to one telephone call."

In addition, Tucker says, a note on the web site lets patients know that copays and deductibles are due at the time of service and reminds them to bring their identification and insurance card.

"We also have maps on the web site they can use if they haven't been to the hospital before," she says, noting that providing directions is something that typically is done in the preregistration phone call.

One of the few problems customers have had in completing the on-line registration process has been selecting the correct hospital as the destination for their form, Tucker notes. "We have several different facilities, so we've had to tweak the web site so that is more noticeable — that's probably the biggest challenge we've had."

Once the patient has completed the on-line registration, it moves automatically to a mailbox that actually is a computerized work list, she explains. "The preregistration person enters the demographics into the admission/discharge/transfer system, completes the insurance verification, and then calls the patients to let them know we've received the information."

At that point, the employee tells the patients the amount of the copay or deductible and where to come when they arrive at the hospital, Tucker

says. "It's a much shorter phone call [than with the traditional preregistration process]."

Future plans, she adds, include enabling patients to make payments on-line, so they can take care of the copay or deductible in advance.

"It's going to be a pretty big project," Tucker says, "because we'd like it to be not only for payments on that visit, but for existing accounts."

[Editor's note: Liz Tucker can be reached at (901) 227-3883, or by e-mail at liz.tucker@bmhcc.org.] ■

Shelter with follow-up care helps homeless

Provides shelter for patients 24-hours a day

An innovative homeless shelter — where people who need post-discharge medical care are allowed to stay 24-hours a day — is freeing up hospital beds for more acute patients and providing ongoing benefits to individuals who typically access the health care system only through the emergency department (ED).

The effort began, says **Kate Tenney**, manager for case management at Sutter General Hospital in Sacramento, CA, when representatives of homeless services in the community asked to talk with hospital officials about homeless people who were being discharged from a facility but still needed follow-up care.

"In California, if you are going to have home care, you have to have a home," adds Tenney. "They won't see you on the street or in a car. Homeless people who had no address and no physician were showing up at shelters with dressings that needed to be changed."

When Sutter case managers met with advocacy groups, which included the Salvation Army, they brought along case managers from two other major hospital systems, she says. "We decided that what we needed were shelter beds where patients could stay 24-hours a day or could come there and get services during the day."

To establish the interim care facility, each of the hospital systems donated $50,000, and the state of California contributed $150,000, Tenney says.

The facility opened in April, has a capacity of 18, and averages about eight to 12 patients a day, she adds.

Only individuals with a medical need — such as keeping a leg elevated or having a dressing changed — are allowed to stay in the 24-hour shelter, Tenney says, noting that homeless shelters normally are open only at night. "We have been very conservative about who we send there — we didn't want anything to go wrong."

A part-time nurse makes sure the patients follow physician orders, keep their wounds clean, and get to their scheduled appointments, she notes.

One recent shelter patient was an 18-year-old — whose family lives on the river — who had broken her leg, Tenney says. Only the girl stayed in the shelter, she adds, because the rest of the family didn't need to be there.

Prime candidates for the shelter are homeless patients who are in need of surgical procedures but otherwise wouldn't be allowed to have them because of physicians' concerns that they couldn't take care of themselves afterward, Tenney explains.

"There was one gentleman — in his 40s and with an alcohol problem — who was hit by a car a number of years ago and needed to have pins removed and reconstruction done to both ankles," she says. "He had needed [the surgery] for a while but had to be able to do dressing changes because an infection could have made him lose his legs.

"He came in and said the physician wanted to do the surgery if he could get into the interim care program," Tenney adds. "I saw him a few days ago, and he was up and around. Home health [nurses were] coming by [the shelter] to give him wound care and intravenous antibiotics."

Without the support provided by the shelter, notes **Barbara Leach**, director of case management for Sacramento Yolo Sutter Health, the man "never would have had the surgery or would have had it and been stuck in the hospital, [becoming] someone who could not be discharged and would be staying for free."

In addition to preventing the financial shortfall that results from the hospital stay of a nonpaying patient, she says, "[the program] opens up hospital beds that we otherwise would not be able to place patients in."

"In the past, with the logistics of the homeless, the only real access to care is through the ED," Tenney adds. "If [they] call the doctor's office and say, 'I need to come see you,' if there's no insurance, the likelihood is they'll be turned away.

"If they go to a community clinic, they'll be put in line with everyone else who needs a procedure; and it might be a long time before they get

what they need," she continues. The simplest way of accessing care has been to wait until they're very ill and walk into the ED."

Another benefit of the interim care shelter is that it provides links to community resources that the patient otherwise wouldn't have known about, Tenney points out, "like finding them a primary care physician or a drug rehab program, or getting them into a clinic for ongoing medical care and getting that funded."

For some of the homeless patients, many of whom don't have insurance, staying at the shelter provides the opportunity to get qualified for Medicare or Medicaid, she adds.

Getting funded

The aspect of the program that is of most concern at present is procuring the funding to continue it when the initial allocation comes to an end in April 2006, says Tenney. One of the challenges, she notes, has to do with measuring the initiative's effectiveness.

"We have to come up with some way of showing success," Tenney says. "We don't know what that looks like. Is it a certain bed capacity, the fact that it's still running? We're not quite sure what we will use."

Originally, the idea was to keep track of the hospital days saved when a person is at the shelter instead, she adds, "but there's not a real correlation between a stay at the homeless project and a stay at the hospital. A lot of the [shelter residents] we wouldn't have kept in the hospital."

Another possibility, Tenney notes, is to look at the cases in which a person initially was unfunded and classified as self-pay and then on the next visit was on Medicaid.

Because the federal government gives money to the state to impact homelessness, she adds, another way to measure success might be to take credit for getting people off the street.

One of the things that makes the project unique, Leach points out, is that it involves the collaboration of three competing hospitals. That kind of cooperative arrangement is particularly difficult in the state of California, because of laws designed to prevent monopolies from forming, she says. "It's exciting because there are no such laws around [projects of] community benefit."

(Editor's note: Kate Tenney can be reached at tenneyk@sutterhealth.org. Barbara Leach can be reached at leachb@sutterhealth.org.) ■

Collaborative spirit marks success of eOrder pilot

Weekly debriefings were key

Cooperation and collaboration have been the keys to success in the trial run of a new process for screening orders for medical necessity at the point of care — in the physician's office — and electronically sending them to the hospital, says **Margie Winfield**, RNC, manager of the same-day surgery and presurgical testing departments at Advocate Good Samaritan Hospital in Downers Grove, IL.

The initial reaction of the office staff was, "'Oh, my gosh — we'll never have time for this,'" Winfield notes. But she says weekly meetings of hospital and physician office personnel with representatives of Oakbrook Terrace, IL-based Nebo Systems, designers of the electronic order system, eventually led to "an upward swing on the learning curve."

The regular Thursday updates and debriefings — at which vendor representatives made a work list they took to Nebo programmers — resulted in some unexpected side benefits, Winfield adds, including an innovation the hospital expects will be a big selling point as it rolls out the process to other physician practices.

The hospital's goal with this piece of the project, which ultimately will involve a total redesign of the outpatient testing process, is to "eliminate unintentional conflict between diagnosis and procedure codes on outpatient physician orders prior to the delivery of service."

Tackling the problem with code scrubbing

The problems occur, she says, when patients arrive at the hospital for testing with incomplete, handwritten orders that might or might not include a diagnosis. That diagnosis might or might not meet the Medicare criteria for medical necessity for the procedure being ordered, and there is "no coding information at all," Winfield continues.

Recognizing that many of its physicians have not made the transition to computer technology, the hospital's "code-scrubbing" team developed a noncomputerized form containing "a pretty comprehensive list of frequently ordered tests," she says.

With participation from all the departments that provide outpatient testing, the team "assigned codes where appropriate, and gave a sample listing of diagnoses and codes for some major [procedures], like CAT scans," Winfield says.

"We let them know that it wasn't a comprehensive list, and we referred them back to Medicare regulations [if more information was needed], but it gave us a much cleaner order from the get-go," she adds.

That form, which is an improvement on the old prescription pad orders, can be faxed to the hospital from the physician's office, if the office is not equipped with the electronic order system, Winfield continues. "We are hoping to increase physician office staff, hospital staff, and patient satisfaction."

Even in the case of the three physician offices participating in the pilot program implementing the Nebo eOrder system, she explains, "we had them fax the order in the beginning, until we got through the learning curve, to see if the forms would work. For a while, we were doing both [faxing and sending electronically] until their comfort level increased."

Now the pilot office puts the forms in the exam

Patient Info **Electronic Order to GOOD SAMARITAN HOSPITAL**

7/29/2005 4:01:25 PM

Practice Name	DEMO ACCOUNT
Address	1 MAIN STREET MYCITY, IL 60540
Phone No	630-555-1212
Physician Name	FREDRICKSEN ROY E
Patient Name	MURPHY TEST N
Address	123 NEBO STREET LEMONT IL 60439
Phone No	630-257-5555
DOB	10/9/1961
Diagnosis Codes	4019 7840 2720
Ins Co Name	BLUE CROSS BLUE SHIELD
Ins ID / GRP No	8812345 / XOH007

Good Samaritan Appointment Information

- Walk-in lab services are available: Mon-Fri 6 a.m. - 7 p.m. (Must register by 6:30p.m.). Sat 6 a.m. - 2:30 p.m. Closed Sun/Holidays. For questions call (630) 275-5580.
- For MRI appointments, call (630) 275-3602.
- For tests requiring an appointment, call scheduling at (630) 275-APPT (2778).
- For PT/OT/Speech at Good Samaritan Hospital, call (630) 275-1036. For PT/OT at Good Samaritan Health and Wellness Ctr., call (630) 275-2600. For PT/OT at Lemont Good Samaritan Professional Building, call (630) 243-7100.

Rev Code	HCPCS	Panel	DOS	HCPCS Description	HCPCS to Diagnosis	HCPCS to HCPCS	Frequency Sensitive
352	73701	S86 : CT Scans: Lower Extremity	07/29/2005	CT LOWER EXTREMITY W/DYE	STOP	Pass	N/A
301	82465	D25 : NCD: Lipids	07/29/2005	ASSAY, BLD/SERUM CHOLESTEROL	Pass	Pass	N/A
730	93005	S9 : Electrocardiography	07/29/2005	ELECTROCARDIOGRAM, TRACING	Pass	Pass	N/A

Final Medical Necessity Outcome	STOP

Needs ABN ☑

Financial Responsibility explained to patient ◉ Yes ○ No

Remarks: Please fast 12 hours. Report to the outpatient registration area prior to testing. Your first appointment is in Cardiology at 9 a.m.

Source: Good Samaritan Hospital, Downers Grove, IL.

room, where the physician uses them, instead of the prescription pad, to write the diagnosis or description of symptoms, Winfield adds.

"Then the front-desk [employee] enters the order into Nebo's eOrder system," she says. "If the diagnosis and description do not meet the requirement for that test, a red stop-sign symbol comes up. If it goes through, there's a nice green pass sign."

Although the medical necessity screening is required only for the orders of Medicare patients, Winfield notes, "we decided it was easier to have them put all the orders through the system."

Doing the screening on-site, she says, gives staff the ability to ask the physician for more information before the order leaves the office. "They can ask, 'Is there something you didn't put down?'"

That opportunity for clarification, she adds, "gives the order a much better chance of passing all the rules and regulations."

The eOrder product is part of the vendor's web-based practice management system, Health Nautica, but also can be used independently of that system, notes **Katherine H. Murphy**, CHAM, patient access coordinator for Nebo.

Training of the office staff, primarily entry-level employees with no coding background, "was very basic at first," Winfield says. Their feedback on the Windows-based Nebo product, however, "was that it was user-friendly," she adds, noting that most of the employees had Internet skills and were accustomed to accessing the hospital's CareNet.

It helped that the office's billing clerk had some knowledge of coding and meeting diagnosis requirements, she says.

Tweaking the process

One of the issues office personnel brought up in the weekly meetings, Winfield says, was that if they found a diagnosis that met the test criteria, they then had to enter it into the eOrder system themselves. "They said, 'Why can't we just click on it, and have it populate the screen?'"

Nebo programmers tweaked the system to make that possible and, in response to another concern, added a field where, if necessary, staff could put clarifying remarks that could be printed on the copy of the order that is given to patients, she explains.

"Before some tests, for example, you have to [fast] for 12 hours; and for some, you have to make an appointment, while for others, you can just walk in," Winfield adds.

The order screen the hospital receives, she notes, "looks totally different" than the version that is printed out for patients, "because we don't need all the information they get." **(See sample screen, p. 104.)**

One stumbling block that needed to be removed had to do with the hospital's need to receive, along with the order, the demographics of the patients, Winfield says.

"Unfortunately, the office management system in the pilot office was old and didn't integrate with the Nebo system," she adds, "so we had all the demographics in one file, but they couldn't be pulled over to populate the Nebo file."

The hospital ultimately decided to cover the cost of updating the office management system, Winfield says.

"That way, when the patient's name or Social Security number is typed into the Nebo product, the demographics can be pulled over automatically, so the [office employee] doesn't have to enter them," she notes. "It's very time-intensive to do that in a physician's office, and we wanted to make the process as streamlined as possible."

The office staff now are extremely pleased with the new process, which has dramatically reduced the phone calls to and from the hospital in pursuit of a complete and accurate order, Winfield adds.

There still are a few orders that need to be tweaked by hospital coders, she says, in some cases, because they required a code the office staff were not aware of. "[Coding] is a skill that people go to school to learn," she points out.

The ironing out of those glitches, Winfield adds, has been another example of how collaboration and cooperation have prevailed.

An unexpected benefit

One of the side effects of the project — and "almost the biggest perk of the whole thing," according to the office manager — was an update by the vendor that made it possible to run a report on all the orders that had been put through for each patient, she says.

Thanks to that modification, she notes, the physician's office "will have a viable list of orders that have been given to patients, and as the results come back to the office, can check that off."

"They can see that, 'Oh, we ordered an EKG for Mrs. Smith, and she hasn't had it yet,'" Winfield

says. "Before, there was no way to tell unless they went through every chart."

With the liability concerns associated with patients who don't follow through on physicians' orders, she adds, the ability to keep that checklist is a huge advantage.

An important benefit of the eOrder process, in general, is the built-in patient-safety enhancement, Murphy notes.

When patients who have difficulty communicating — those with a language problem, for example — arrive at the hospital for a test or attempt to schedule an appointment over the telephone with just a scribbled physician order, there always is the danger of a misunderstanding, she points out.

"Normally, hospital staff can't see the order, but now they'll have it," Murphy adds.

[Editor's note: Margie Winfield can be reached at (630) 275-1720. Katherine Murphy can be reached at Nebo Systems at (630) 916-8818, ext. 34.] ■

Could 'bankruptcy bill' help hospitals get paid?

Homestead exemptions addressed

A "bankruptcy bill" signed into law in April will make it harder for consumers to shield their assets and avoid paying off medical bills and other debt, according to some industry observers.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, much of which goes into effect Oct. 17, has provisions that affect corporations, small businesses, and farmers, as well as consumers.

Although the bill was passed with the stated intent of increasing personal responsibility and integrity, opponents contend it could harm consumers with a legitimate need to declare bankruptcy.

Information about the aspect of the bill that concerns homestead exemptions has been circulating among access professionals, many of whom believe it will go a long way toward helping hospitals get paid, since a great percentage of bankruptcy filings are prompted by medical debt.

"Due to the tougher regulations surrounding the new bankruptcy law, more medical debt will be repaid rather than cleared by persons who might have filed under Chapter 7 in the past," says **Patti Daniel**, CHAM, policy development/government relations chairwoman for the Washington, DC-based National Association of Healthcare Access Management.

However, the homestead provision has some limitations that greatly restrict the number of debtors who actually will be affected by it, notes **Loren Ratner**, an attorney specializing in health and hospital law in the Health Services Group of Nixon Peabody LLP in its Garden City, NY, office.

Law limits exemptions in some states

The law places new limits on the use of state homestead exemptions in bankruptcy filings, Ratner says, but she points out that only a handful of states have unlimited homestead exemptions (meaning an unlimited amount of equity in the debtor's home is protected from creditors).

According to congressional reports related to the act, states with unlimited homestead exemptions include Florida, Iowa, Kansas, South Dakota, and Texas, plus the District of Columbia, Ratner explains. "Under the new law, a debtor may not claim a homestead exemption of more than $125,000 if the debtor purchased the home within 1,215 days (40 months) of his or her filing for bankruptcy," she says.

"In addition, the debtor cannot exempt more than $125,000 under a state homestead exemption if the debtor engaged in criminal conduct or violated securities law," Ratner adds.

A debtor also is not allowed to use a state's homestead exemption, she says, if he or she moved to that state within 10 years prior to filing bankruptcy to take advantage of the state's more generous homestead exemption, in an attempt to hinder, delay, or defraud a creditor.

"An example is where the debtor used the proceeds from the sale of securities to build equity in his or her home in order to shield from creditors the money received from the sale of securities," Ratner explains.

"In a nutshell, the changes do place some limits on the ability of debtors to shield the equity in their homes from creditors, but it is limited to those states in which debtors have unlimited homestead exemptions, and limited to certain circumstances, such as where the debtor purchased the home within 40 months prior to filing bankruptcy or engaged in certain illegal activity," she adds. ■

Wisconsin EMTALA case offers take-home points

Stabilization issue addressed

A recent decision by the Wisconsin Supreme Court involving the federal Emergency Medical Treatment and Labor Act (EMTALA) offers several take-home points for access managers and others charged with overseeing emergency department (ED) operations, says **Stephen A. Frew**, JD, a risk management attorney and web site publisher (www.medlaw.com) specializing in EMTALA issues.

In the Wisconsin case, Shannon Preston sued Meriter Hospital in Madison, alleging that physicians there refused to treat her infant son, who weighed only 1 pound when he was born 17 weeks premature in 1999, because they believed his lungs were so underdeveloped that he would not survive regardless of what they did.

Preston sued on several grounds, including her contention that the hospital violated EMTALA. A circuit court decided in the hospital's favor, ruling that the federal requirement did not apply to the infant because he arrived through the birthing center, not the ED. The Supreme Court reversed that decision.

"The duty to provide a medical screening examination should not depend on the hospital room — be it the emergency room, the birthing center, or an operating room — into which a baby is born," Justice David Prosser wrote for the majority in the July 13 ruling.

Frew points out that the decision is consistent with the U.S. 1st Circuit Court of Appeals 1999 ruling in the *Lopez-Soto v. Jose Hawayek* case interpreting EMTALA.

"Decisions like this one are likely to force a confrontation [between] the courts following the U.S. Supreme Court lead on EMTALA from the [1999] *Roberts [v. Galen of Virginia Inc.*] case and those seeking to limit the application of EMTALA to its 'intent,' not its literal language," Frew contends.

In the *Roberts* case, the high court held that no showing of improper motive is required to establish a violation of EMTALA's stabilization requirement.

Conflict between courts

The conflict among the courts, Frew predicts, "ultimately will lead to an encore EMTALA presentation to the U.S. Supreme Court, with little indication whether changes on the high court will strengthen or weaken the *Roberts* and *Lopez-Soto* decisions and provide more definitive guidance one way or the other."

Frew says, however, that the Wisconsin decision has a patent logic that makes its argument compelling. He notes that the Centers for Medicare & Medicaid Services (CMS) always has included obstetrics as an ED area in its discussion of EMTALA and points out that the duty to provide care is ongoing until the condition is stabilized.

"An OB patient is stabilized when the hospital has delivered the baby and placenta," he says, "and the defendant in [the Wisconsin] case wanted to say that the EMTALA duty stopped at that point and that the baby had not presented for EMTALA purposes."

The definition of "presenting," Frew adds, includes arrival on the premises and someone asking for care. "Clearly, the baby arrived on campus in the mother's womb," he says, noting that the language in the EMTALA law clearly considers the fetus a separate entity. "It is ludicrous to suggest that the mother asked for help for herself and not her baby."

He goes on to point out that while the hospital argued that the infant was not viable, younger children do survive, and 22 weeks is within the standard that most hospitals use for viability.

"Without a documented assessment, it would be difficult to demonstrate whether or not the infant was viable, and the burden under EMTALA rests with the hospital," Frew says.

"The plaintiff alleges that a medical screening exam [MSE] was not given, and without an MSE, it is again difficult to argue that providing care would have been futile," he adds.

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He suggests hospitals take away the following points from the case:

1. Obstetrics presentations are covered by EMTALA in the labor and delivery area or the ED.
2. The baby is a separate patient covered by EMTALA when the mother presents and has separate EMTALA rights.
3. It is dangerous to try to distinguish emergency duties for patients in the unit from those in the ED, "and you take your chances both with CMS and with malpractice cases where it will be hard to defend double standards," Frew says.
4. It is always "difficult to impossible" to establish that reasonable care was taken without detailed examination findings and policies and procedures to back you up, he adds.

CMS advisory related to case

An advisory issued April 22 by CMS, meanwhile, addresses the interaction between the Born-Alive Infants Protection Act of 2002 and EMTALA, Frew notes.

The advisory was prompted, CMS stated, because "it has recently come to the agency's attention that there may be occasions where, in hospitals, an infant may be born alive within the meaning of the definition added to the United States Code by the Born-Alive Infants Protection Act of 2002, but where hospitals have failed to comply with the requirements of EMTALA."

The CMS advisory amended the language in the U.S. code so that "in determining the meaning of any act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person,' 'human being,' 'child,' and 'individual,' shall include every infant member of the species Homo sapiens who is born alive at any stage of development."

In discussing EMTALA applicability, Frew says, CMS uses examples of a child born in the labor and delivery room, or on the hospital campus outside the labor and delivery room.

It also notes, he adds, that a child who is admitted to the hospital would not be covered by EMTALA under the current CMS view but would definitely be covered by the Medicare Conditions of Participation.

Frew advises those investigating EMTALA complaints as follows:

"EMTALA is a complaint-driven statute. If you receive a complaint that suggests that a born-alive infant has been denied a screening examination, stabilizing treatment, or appropriate transfer, you should treat the complaint as potentially triggering an EMTALA investigation of the hospital," he continues.

"Note that it is not necessary to determine that the hospital acted with an improper motive in any failure to provide a screening examination, stabilizing treatment, or appropriate transfer, in order to conclude that an EMTALA violation has occurred," Frew adds. "The Supreme Court of the United States has held that a finding of improper motive is not required to conclude that an EMTALA violation has occurred." ■

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

Ruling on criminal prosecution under HIPAA raises furor

Critics say legal opinion will allow those who abuse privacy information to escape prosecution

A Department of Justice legal opinion, issued at the request of the Department of Health and Human Services (HHS), stated that only covered entities and those people rendered accountable by general principles of corporate criminal liability may be prosecuted under criminal enforcement provisions of the HIPAA Administrative Simplification section.

The opinion has been attacked by privacy advocates, who say it will allow people who misuse privacy information to escape prosecution.

HHS had asked whether the only people who may be directly liable are those to whom the substantive requirements of the subsection apply — health plans, health care clearinghouses, certain health care providers, and Medicare prescription drug card sponsors — or whether the law may also render directly liable other people, particularly those who obtain protected health information in a manner that causes the person to whom the substantive requirements of the subtitle apply to release the information in violation of the law.

Who is liable?

In the opinion he wrote for HHS, **Steven Bradbury**, principal deputy assistant attorney general, said the department had concluded that health plans, health care clearinghouses, those health care providers specified in the law, and Medicare prescription drug sponsors may be prosecuted for violations of Section 1320d-6.

In addition, he said, depending on the facts of a given case, certain directors, officers, and employees of these entities may be liable directly under Section 1320d-6 in accordance with the general principles of corporate criminal liability, as those principles are developed in the course of a particular prosecution.

"Other persons may not be liable under this provision," Bradbury wrote. "The liability of persons for conduct that may not be prosecuted directly under Section 1320d-6 will be determined by principles of aiding and abetting liability and of conspiracy liability."

While Bradbury did not go into detail on the principles of corporate criminal liability, he noted that, in general, the conduct of an entity's agents may be imputed to the entity when the agents act within the scope of their employment, and the criminal intent of agents may be imputed to the entity when the agents act on its behalf.

"In addition, we recognize that, at least in limited circumstances, the criminal liability of the entity has been attributed to individuals in managerial roles, including, at times, to individuals with no direct involvement in the offense," he wrote.

"Consistent with these general principles, it may be that such individuals in particular cases may be prosecuted directly under Section 1320d-6," Bradbury continued.

Other conduct that may not be prosecuted under Section 1320d-6 directly may be prosecuted according to principles either of aiding and abetting liability or of criminal liability, he wrote.

Attorneys surprised at HHS direction change

The ruling limiting prosecution came as a surprise and a disappointment to many privacy advocates and attorneys.

Peter Swires, a law professor at The Ohio State University in Columbus who was chief counselor for privacy in the Office of Management and Budget in the Clinton administration, tells *HIPAA Regulatory Alert* that this opinion is helping the

Bush administration turn the medical privacy law into little more than a voluntary standard.

"Unless the administration pulls back from its current position, it will be up to Congress to protect privacy and say that obviously criminal behavior should be punished by criminal law," he says.

Swires says he has heard that the department pushed hard for this ruling, much to the consternation of some Justice Department attorneys who don't agree with it and are looking for other ways to prosecute those who misuse privacy data.

According to Swires, the HHS Office of Civil Rights (OCR), which has been given the job of civil enforcement of HIPAA, has done little to address the more than 13,000 HIPAA privacy complaints it has received in the past two years. OCR has yet to bring a single enforcement action, he says, and that lack of enforcement sends a signal to covered entities "that HHS will not act even against flagrant violations of the privacy rule."

With no civil enforcement actions, the only success has been on the criminal front, Swires says, and that involves just one case — a hospital lab phlebotomist who accessed the records of a patient with a terminal cancer condition, got credit cards in the patient's name, and ran up more than $9,000 in fraudulent charges, mostly for video games.

Under a plea agreement, the lab technician was sentenced to 16 months in jail. At the time the technician was prosecuted, the Department of Justice said the case "should serve as a reminder that misuse of patient information may result in criminal prosecution," but Swires says it now is possible he will have to be released because under the new opinion he could not be criminally prosecuted because he is not a covered entity (although it is possible he could be prosecuted for identity theft).

Swires says these are among the reasons why the opinion is bad law:

1. The statute applies to "a person who knowingly and in violation of this part. . . ." While the opinion defines "person" only as a covered entity, Swires says the natural reading would include hospital employees who abuse medical records.
2. The criminal statute includes jail time, and real people are sent to jail, not hospitals and health insurance companies.
3. The attorneys who wrote the opinion overlook the fact that Congress made it a crime for any person to illegally obtain health information and insist that Congress was not concerned about criminal activities by outsiders who steal medical records or by insiders who sell medical records or use them for their own advantage, but rather Congress only wanted to target covered entities.

Robert Gellman, a privacy consultant, tells *HIPAA Regulatory Alert* that problems with misuse of medical records are much more likely to involve lower-level staff people in health care organizations who have access to the records than the physicians who are covered.

"Whether there are other criminal penalties that can be applied to those who have been let off the hook by the opinion remains to be seen," he continues.

Gellman says one reason the department might have pushed for this opinion is that it will mean less work to be done and the agency already has shown in civil enforcement that it doesn't want to do much work.

"It appears that OCR has little interest in HIPAA," he adds.

Greatest impact may be in the future

In the short term, the opinion may not have much of an impact because there already is very little enforcement, Gellman points out.

In the longer term, it may affect President Bush's initiative for more electronic health records and a national health information technology effort, he says.

"HIPAA came about initially because Congress wanted more electronic health transactions," recalls Gellman. "But if more people are able to retrieve more medical information, how can you justify the technology and build public support without a policy to protect privacy?"

Emily Stewart, Health Privacy Project policy analyst, tells *HIPAA Regulatory Alert* the opinion came as a surprise and is seen as a "real blow to consumers in terms of the kinds of recourse they have when their privacy is invaded. It severely weakens the force of a law that is already weak in enforcement." She says her group has a consumer coalition on health privacy and has been talking to the other members about possible steps to strengthen privacy protections.

"We find it very ironic that the Bush administration continues to push for a national health information network without providing good safeguards to protect privacy of health information," Stewart says.

HHS also had asked for an explanation of the element in the criminal enforcement section that talks about enforcement against those who knowingly use or cause to be used a unique health identifier, obtain individually identifiable health information relating to an individual, or disclose individually identifiable health information to another person.

The question from HHS was whether the provision requires only proof of knowledge of the facts that constitute the offense or whether it also requires proof of knowledge that the conduct was contrary to the statute or regulations. The Department of Justice said it had determined that the reference was only to knowledge of the facts constituting an offense.

"A plain reading of the text indicates that a person need not know that commission of an act described in [the subsections] violates the law in order to satisfy the 'knowingly' element of the offense," Mr. Bradbury wrote. "Section 1320d-6 makes the requirements that the act be done 'knowingly' and that it be done 'in violation of this part' two distinct requirements. . . . Accordingly, to incur criminal liability, a defendant need have knowledge only of those facts that constitute the offense." ■

Hospitals don't want fined entities identified

The American Hospital Association (AHA) says it is "troubled" by a Department of Health and Human Services (HHS) plan to publicize the identity of those covered entities given civil monetary penalties under enforcement of HIPAA's administrative simplification section.

The association also says it is especially concerned over the department's expectation that consumers will use the information to help choose a health care provider.

In written comments to HHS, **Melinda Reid Hatton**, AHA vice president, said hospitals had asked that HHS make available to covered entities information about violations, proposed solutions, and good practices in a form that did not identify violators.

"Making information available in an unidentified format would allow covered entities to understand how the Office of Civil Rights and the Centers for Medicare & Medicaid Services interpret and apply the HIPAA regulations in specific cases and would encourage remediation of problems and violations discovered through the enforcement process," she said.

"The information would enable covered entities to gain a better sense of the types of compliance problems that are occurring and the misunderstandings that exist regarding application of the HIPAA regulations," Hatton explained.

But the notion that information about violations of HIPAA technical requirements is useful to consumers is flawed, she noted.

"Consumers should not make their health care decisions based on HIPAA's technicalities. These are irrelevant to the quality of care patients receive from a provider. As the number of complaints filed with the Office of Civil Rights for incidents that are not HIPAA violations suggests, many consumers do not understand these complicated rules," Hatton added.

Moreover, she said, although health care consumers who are informed that a hospital violated the HIPAA medical privacy rule are likely to believe the hospital does not adequately protect patient privacy, most violations of the medical privacy rule are not the result of an impermissible use or disclosure of patient information and are likely to be only technical in nature.

AHA said it appreciates that compliance with technical requirements of the administrative simplification provisions, including the technical requirements of the HIPAA medical privacy rule, is important and that accrediting entities need to know of these facts.

However, it said, the potential for seriously misleading the public about the meaning of the medical privacy rule violations where no impermissible use or disclosure occurred is an unwarranted and irresponsible policy.

Methodologies not easy to understand

Hatton also pointed out that the methodologies used to establish violations and penalties, such as statistical sampling and the number of days a requirement was not met, are not easy to understand.

She cited an example of a potential publicized violation of a hospital that had 1,100 violations of the medical privacy rule in a 90-day period, when the violations would refer to nothing more than that the hospital was unable to document that its Notice of Privacy Practices was acknowledged by people admitted to the emergency department or

that the department had determined that processes used to collect data for the accounting of disclosures with respect to 1,100 patients do not have all the details needed to comply with its guidance.

"As a result," she said, "a statement that Hospital A paid several thousand dollars in fines due to 1,100 violations of the privacy rule arguably is misleading and could panic individuals into distrusting their provider."

In other comments, Hatton:

- endorsed the department's continued emphasis on voluntary compliance;
- urged the Office of Civil Rights and the Centers for Medicare & Medicaid Services to fulfill the enforcement rule's promise to "continue to work on educational and technical assistance materials, including additional guidance on compliance and enforcement and targeted technical assistance materials focused on particular segments of the health care industry";
- called on the government to provide more information to covered entities on the methodologies for establishing any violation and the amount of a penalty;
- expressed concern that the proposed enforcement rule significantly restricts and limits a covered entity's ability to present a defense and appeal an adverse ruling, including imposition of a civil monetary penalty.

[Download the comments from the HIPAA section of www.aha.org. Contact Melinda Hatton at (202) 638-1100.] ■

Transaction standard is far from projected uniformity

The HIPAA transaction standards have not resulted in the uniformity and efficiency envisioned when HIPAA was adopted.

That's the opinion of the HIPAA Implementation Working Group, which were presented in testimony to the National Committee on Vital and Health Statistics.

The group, which represents health care providers, vendors, and clearinghouses, said that for providers, clearinghouses, and many others, standards implementation has yet to result in any clear return on investment.

"The savings predicted by the Department of Health and Human Services of $29.9 billion in administrative expenses over a 10-year period beginning in 2002 are far from view," they said.

"To date, the costs of complying with the Transactions and Code Sets Standards have been significant, and there are no data showing that providers have experienced any return on their investment," the group noted.

The Working Group said significant progress has been made in implementing a standardized electronic claim form through use of the 837 claim transaction.

As 837 use becomes routine, according to the testimony, the industry has begun to discuss implementation of standards for other transactions. Collaboration is increasing among many sectors of the industry to ensure standards have the utility and promote the uniformity envisioned by the law, the group said. In addition, providers and vendors are becoming more active in the standard setting process.

The Implementation Working Group said the benefits of adopting any transaction standard relate primarily to ways in which standardization improves a participant's ability to receive useful detailed information in a timely, uniform, and cost-efficient manner.

"The 837 claim transaction, which has been the primary focus for the HIPAA transition, is bringing limited, if any, benefit to the provider community in part because significant payer-specific customization is still required," according to the group's testimony. "As the focus of implementation shifts to transactions through which health care providers can obtain useful information, the opportunity for a positive business impact from standardization grows. For example, providers expect to see financial benefit from timely and useful patient eligibility, remittance advice, and claim status information."

The group said the degree to which standards implementation has a positive or negative business impact also depends heavily on whether the standards reflect the needs of those who use them. But the current standards do not address the business needs of the provider and vendor communities, due in part to the historically significant representation of providers and vendors in the standard-setting process and in part due to the limited understanding of how the standards would be used in practice.

"We should learn from these experiences and use them to strengthen the standard setting process," the Working Group declared. ■