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Lessons learned from Florida hurricanes informed HCA's response to Katrina

Having resources in place early made the difference

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NOVEMBER 2005

VOL. 25, NO. 10 • (pages 121-132)

Experience gained when hurricanes hit the coast of Florida in August and September 2004 served the Hospital Corporation of America (HCA) well when it came time to respond to the threat of Hurricane Katrina, which devastated the Louisiana and Mississippi coasts in September 2005.

"The lessons learned [in Florida] taught us what to do better in the future," says **Jeff Prescott**, a spokesman for the Nashville, TN-based company, which includes some 190 hospitals worldwide. "A lot of those things we were able to put in place just before Katrina hit."

HCA leadership followed up on several recommendations outlined in an earlier briefing by the company's eastern group president, who had overseen the response to the hurricanes that hit Florida on two coasts, says Prescott, including the following:

- **Pre-position food, water, equipment, and supplies.**

This piece of advice proved invaluable, he notes, and helped put HCA in the position to not only evacuate its own Tulane University Hospital and Clinic, but help to evacuate nearby Charity Hospital's two facilities.

As a large company "with lots of infrastructure and a robust supply chain," Prescott says, "we were able to move a lot of stuff quickly. Not every parent company is able to hire 20 helicopters.

"By virtue of that," he adds, "we were able to [get out] 60 or 70 people from the hospital across the street from our facility when local authorities didn't have enough resources to do it."

The heads-up on arranging the helicopters in advance, Prescott says, was provided by HCA's Florida division president based in Tallahassee, one of the company executives most experienced in dealing with hurricanes.

"He said, 'You will need helicopters — start finding them and getting them under leases,'" Prescott recalls. "We did that a day or so ahead (of the storm)."

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- **You'll need extra linens.**

Staff handling the aftermath of the Florida hurricanes, he says, discovered that when there is wind damage and rain, people will use linens to mop up water. "Then you won't have enough linens."

- **Have the ability to switch electrical sources quickly.**

"You have to have additional generators and have the ability to connect them to outlets and equipment in the hospitals," he says. "If it's a long time [before power is restored] the regular generator doesn't run everything. You might need more."

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

Subscriber Information

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

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

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It's also important to remember that special connections are necessary to put the generators in place, Prescott adds. "You can't just plop them in the back yard and hook up."

- **Get satellite telephones.**

In anticipation of the likelihood that cell phones, which require a tower, won't work during a hurricane, HCA bought a large number of satellite phones and put them in hospitals before the storm hit, Prescott notes. "They're still not infallible, but when land lines don't work, we did have some in place and were able to use them."

Hospital officials found out early in the evacuation process, however, that even with satellite telephones, they couldn't communicate with people in helicopters.

"By this time, we had helicopters coming in with supplies, dropping those off, and picking up patients," Prescott explains. With the normal takeoff/landing area under water, he says, helicopters took off from a parking garage roof from which the light poles had been removed.

"The patients initially were taken to hospitals an hour and a half away, but then, in the case of less critical patients, they started taking them to a staging area at the New Orleans airport," Prescott continues. After dropping off those patients at the airport — where they were triaged by nurses and then taken on buses to other facilities — the helicopter could make a quick hop back for more passengers, he says.

"So now we've got a helicopter flying back and forth, but no way to [communicate]," Prescott says. The solution came when someone suggested using ham radios, he adds. "We put one at the parking garage, one at the airport, one at the division office in North Florida, which could call us because they're fine there."

The questions going back and forth, he notes, were things like, "How many helicopters are at the airport? How many are in the air? How many patients are left?"

When the pilot was ready to bring the helicopter back for the next group of patients, Prescott adds, he could ask, "What supplies do you need at the hospital? Do you need water, diesel fuel? What's the priority right now?"

Staffing, family concerns addressed

To move employees to different facilities as needed in the hurricane's aftermath, HCA made use of All About Staffing, its internally run temporary nurse staffing organization, he says. "We

have hundreds of nurses all over the country on stand-by that we were able to access.”

The agency also was used to help patients and employees displaced by the storm, Prescott adds, noting that HCA was committed to keeping every employee whose job was impacted by Katrina on the payroll until he or she found another job in the company.

To ensure that Health Insurance Portability and Accountability Act (HIPAA) requirements were followed precisely, he says, HCA ended up giving patient names to the Louisiana Hospital Association to post on its web site for the benefit of family members who might be looking for them.

Patients who were evacuated from hospitals, Prescott notes, were accompanied by a “standard transfer record” that would be used in any patient transfer. At HCA hospitals, he says, 60% to 80% of the patient record is electronic. “We are able to access the vast majority of records because [individual hospitals’ data are] networked to a regional data center.” ■

Hospital status system helps in state evacuation

Mississippi network already in place

A web-based system for monitoring bed availability and transferring patients to other facilities helped mitigate the effects of Hurricane Katrina in Mississippi, says **Jim Craig**, director of health protection for the Mississippi Department of Health.

The system was founded in 1996 in response to a large-scale exodus of physicians from Mississippi because of its tort laws, Craig notes. That exodus, he says, resulted in some health services not being available in parts of the state, and created the need to monitor health care availability.

As part of the planning for potential terrorist attacks, Craig adds, the system was enhanced to allow the tracking of bed availability throughout the state.

Staff at the Mississippi Hospital Association (MHA) “were asked to physically call all the hospitals and ask them to log on to the status system,” notes **Shawn Lea**, an MHA spokesperson. “[The questions were], ‘How many beds are available at your hospital and do you have the

staff to handle them, or do you need assistance?’

“It’s a computer network that can be used in emergency situations to evacuate, for example, dialysis patients who need power and water [for their treatment],” Lea adds.

In the response to Hurricane Katrina, the system was used to transfer patients in advance of the storm to make space for those who might need care in its wake, Craig explains. “When the storm comes to town, we discharge those who can be discharged without risk, and move [others] through the system to make beds available.”

Through use of the system, Craig says, beds were opened up within 72 hours of landfall through both discharge and distribution, and within six days, close to 2,000 beds were available. A portable, 100-bed hospital was moved in and set up near Hancock County Hospital in Bay St. Louis, MS, the only facility to be closed as a result of the hurricane, he notes.

As part of the state’s contingency plan, 23 contract ambulances were sent from other areas of the state in advance of the hurricane, Craig says. After landfall, he adds, another 83 ground ambulances — from Florida, Alabama, Tennessee, and as far away as Colorado — were sent down to assist in the emergency operations, as well as more than 100 air ambulances.

Those ambulances were filled with patients with special needs, including nursing home patients and those discharged from hospitals to move out of the area, he explains. “Luck was with us because the nursing homes we evacuated were those most greatly affected.

“A number of nursing homes were without power and [needed] medical resupply,” Craig adds. “That’s why we called in the strategic national stockpile, and within the first 24 hours, we had [them resupplied].”

Most of the state’s hospitals made it through the first 48 hours of the storm, he notes. “We didn’t do a lot of direct movement of patients to a [remote] location. During ‘decompression,’ or the discharge plan, a number of people were sent to other areas, but those in hospitals weathered the storm.”

Two issues — lack of communication and difficulty accessing fuel — stand out as posing a particular problem during the hurricane response, Craig says.

During the terrorism preparedness efforts, the state had placed satellite telephones at all 100 Mississippi hospitals, he notes. “We were happy to have these radios and telephones because the

cell phones didn't work."

There was some difficulty, however, in that people had to get on top of the hospitals and reposition the antennas, Craig says, and even more trouble because the tidal surge rendered inoperable the generators and satellite equipment stored around the emergency department, which is always on the first floor.

In the future, generators will need to be mounted on the roof, he says — just one of the lessons learned from "the largest storm surge we've ever had in Mississippi. The benchmark now is Hurricane Katrina." ■

HIPAA rules clarified to ease emergency care

Information given 'as necessary'

In the wake of Hurricane Katrina, the federal Department of Health and Human Services Office for Civil Rights issued a special bulletin regarding "HIPAA Privacy and Disclosures in Emergency Situations."

The bulletin was issued, officials said, to emphasize how the Health Insurance Portability and Accountability Act (HIPAA) privacy rule allows patient information to be shared to assist in disaster relief efforts and to assist patients in receiving needed care.

Providers and health plans covered by the HIPAA privacy rule can share patient information in all the following scenarios, the bulletin explains.

- **Treatment: Health care providers can share patient information as necessary to provide treatment.**

"Treatment" includes sharing information with other providers (including hospitals and clinics), referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and coordinating patient care with others (such as emergency relief workers or others that can help find patients appropriate health services).

- **Notification: Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care, of the individual's location, general condition, or death.**

The health care provider should get verbal permission from individuals when possible, but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.

When necessary, the bulletin goes on to explain, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

When a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is not necessary to get a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

- **Imminent danger.**

Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public — consistent with applicable law and the provider's standards of ethical conduct.

- **Facility directory.**

Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the person is at the facility, as well as his or her general condition and location in the facility.

The bulletin points out that, of course, the HIPAA privacy rule does not apply to disclosures if they are not made by entities covered by the privacy rule. For instance, the rule does not restrict the American Red Cross from sharing patient information. ■

Normal procedures relaxed for benefits of evacuees

CMS grants temporary eligibility

Many of the normal operating procedures for Medicare, Medicaid, and the State Children's Health Insurance Programs (SCHIP) were relaxed to accommodate the emergency health care needs of beneficiaries and medical providers in states devastated by Hurricane Katrina.

Special evacuee status was granted by the Centers for Medicare & Medicaid Services (CMS) to all those who fled states because of the hurricane, allowing them to apply for a full range of federal benefits without having to produce the normal forms of documentation to verify eligibility.

A new Medicaid and SCHIP application template was developed, through which states were granted the ability — through emergency Section 1115 demonstrations — to provide temporary eligibility for all groups served by those programs. Using the new program, CMS said, evacuees displaced because of the storm are able to quickly enroll in Medicaid or SCHIP in the state to which they have been evacuated by completing a simplified form giving their income and assets, if any.

States were given the flexibility to enroll those evacuees without requiring documents such as tax returns or proof of residency, CMS said, with applications accepted retroactively through Aug. 24. The program will last through Jan. 31, 2006.

Under the waiver, necessary medical services will be delivered to children up to age 19 and their parents, pregnant women, individuals with disabilities, low-income Medicare beneficiaries, and those who need long-term care and meet certain income requirements.

Evacuees receiving services through Texas Medicaid or SCHIP are not charged any out-of-pocket costs, and receive the standard Medicaid benefit package plus certain additional benefits, such as additional mental health coverage. Developed to reimburse Texas health care providers for care provided to Hurricane Katrina evacuees, the program will apply to other states as well, CMS said.

The program also includes an uncompensated care pool to pay for services for those not eligible for Medicaid or lacking health insurance.

Among other Medicaid and SCHIP changes available through the special 1115 demonstration initiative are:

- During the period of presumptive eligibility, the host state is required to verify circumstances of eligibility to the extent possible.
- Host states, at a minimum, will provide their own Medicaid and SCHIP benefit packages to the evacuees.
- Host states must extend the expedited application process to evacuees who may be newly eligible because of new economic circumstances created by the hurricane — that is, loss of job and

income that may have made them ineligible before the storm.

- Host states will submit their estimated expenditures to CMS as a component of their usual cost reporting for determining federal payments.

The latest information on the program is available at www.cms.hhs.gov.

New codes aid billing efforts

In response to a request from CMS, the National Uniform Billing Committee (NUBC) approved a series of new codes to facilitate medical billing for services rendered to victims of Hurricane Katrina.

The new condition code “DR” (disaster related) is intended to help CMS and other health plans identify claims for which the admission is related to a disaster. In addition, CMS has said that long-term care hospitals caring for Katrina evacuees will be excluded from the calculated statistics intended to ensure the average long-term care stay is 25 or more days.

Additional uses for the new claim identifier may be developed as CMS reviews and finalizes future disaster policies.

Other new codes approved by NUBC, acting only as placeholders until implementation, include a new occurrence code, “DR,” and occurrence span code, “MR.” The occurrence code could, for example, capture the date of a declared disaster, like Katrina, while the occurrence span code could capture a date range, when a disaster was declared and when the disaster officially ended.

The codes also could reflect the date that the Federal Emergency Management Association (FEMA) declared an area to be a disaster area.

In addition to these codes, a new value code, “DR,” is intended to record a specific numeric or monetary amount pertaining to the disaster.

Hospital billing personnel dealing with evacuees are urged to check the NUBC web site (www.nubc.org) periodically for additional changes and updates.

Answers to frequently asked questions about general Medicare billing and payment policy may be found at www.cms.hhs.gov/katrina/MedicareFFS.pdf.

ICD-9-CM coding advice for health care encounters in the hurricane aftermath is available at www.ahacentraloffice.com/ahacentraloffice/images/Katrina. ■

Tracker follows patients through each step of care

Wait time dramatically reduced

A computerized “patient tracker” developed in-house at the University of Arkansas for Medical Sciences (UAMS) in Little Rock is being put to particularly effective use at the Myeloma Institute for Research and Therapy (MIRT), where patients move back and forth among different treatment areas during extended stays.

Perhaps the only institution in the country that exclusively treats multiple myeloma, the institute draws patients from all over the world, notes executive director **Betsy Baldwin**, MSHA. “More than 80% of our patients are not from Arkansas, so when they come here, they usually stay a while.”

During stays that may be as long as two or three months, Baldwin says, patients undergo a lot of testing, including magnetic resonance imaging, bone marrow biopsies, PET scans, bone density tests and many other laboratory tests.

The institute does many stem cell transplants, which require patients to go through a lengthy process that includes donating their own stem cells, and are typically preceded by several weeks

of chemotherapy, she adds.

Typically, some 200 myeloma patients are in town at any one time, she says. About 50 of those have just received stem cell transplants, are going through the recovery process, and are being tracked on a daily basis.

“All the while they’re here, they may be anywhere — on campus, off campus, in their hotel — but if they’re on campus, we want to know where they are,” Baldwin says. “The idea behind the patient tracker is to find out where the patient is at any given time.”

Patients being treated for myeloma, she notes, might be in the outpatient transplant unit, the inpatient transplant unit (both in the UAMS Medical Center), the chemotherapy room or the myeloma clinic, both of which are in the Arkansas Cancer Research Center (ACRC), among other locations, she adds. “They’re pretty spread out.”

When a patient checks in at the clinic waiting room, he or she is also “checked into” the patient tracker before registration takes place, she explains. “As patients move through the system, they are discharged [on the tracker] from one place and put in another.” (See screen shot, below.)

Although staff at the check-in desk now document patients’ arrival in the appointment system and then separately activate them in the patient tracker, Baldwin notes there are plans to merge

Tracking System Follows Patient Flow

The screenshot shows a software window titled "Tracker Grids" with a menu bar and several buttons: "Exit", "Add Pt", "Update Appts", "All Patients", and "Re-Activate Patient". Below the buttons is a tabbed interface with "Current Patients" and "Appt List" selected. The main area contains a table with the following columns: PtName, ApptType, Prov, I, O, ApptTime, Protocol #, Loc, LTime, RN, I, O, I, O, and Comment. The table lists 15 patients with their respective appointment details.

PtName	ApptType	Prov	I	O	ApptTime	Protocol #	Loc	LTime	RN	I	O	I	O	Comment
PATIENT1, M	Follow-up	VANRH			09:00		746	98						
PATIENT10, F	Follow-up	BARLO			11:00	98-026	758	64						
PATIENT11, D	Follow-up	BARLO			10:30	96-015	755	63						
PATIENT12, W	New Pt	PINED			10:00		WR	60						
PATIENT13, R	Follow-up	PINED			08:00	2000-48	734	51						
PATIENT14, C	Follow-up	ANAIS			10:00	2003-41	WR	81						
PATIENT15, D	Follow-up	HOLMI			10:15	2000-52	759	63						
PATIENT2, C	Follow-up	ANAIS			08:15	2001-37	740	154						
PATIENT3, H	Follow-up	HOLMI			09:00	2003-33	760	124	TLB					Research visit complete
PATIENT4, G	Follow-up	VANRH			10:00		747	78						
PATIENT5, B	Follow-up	TRICO			10:00	2001-12	WR	72						
PATIENT6, J	Follow-up	PINED			09:00	98-026	735	70						
PATIENT7, P	Follow-up	TRICO			09:00	98-026	756	140						
PATIENT8, S	Follow-up	ANAIS			09:00	2003-33	753	112	JRU					md notified via cell pt ready.
PATIENT9, Y	Follow-up	BARLO			10:00		754	68						

Source: University of Arkansas for Medical Sciences, Little Rock.

One patient tracker leads to another

Idea got start in UAMS ED

A patient tracker used throughout the University of Arkansas for Medical Sciences (UAMS) had its beginnings when an information technology support person for the emergency department (ED) was asked to replace the “white boards” that were being used to keep up with patients’ location.

“[ED managers] decided they didn’t want to use the white boards anymore, but wanted something that could be displayed,” says **Terry Lewallen**, the UAMS IT software developer who was given that mission.

Lewallen designed what he now says was “an archaic system — like large TVs — that staff could see from anywhere in the department.”

After a while, Lewallen says, managers from a new UAMS clinic, the Center for Aging, heard about the system, came to look at it, and asked him to design something similar for them. He did that, more clinics made inquiries, and before long he had done several such projects, each “a little different” from the others.

In the summer of 2004, realizing he was making more and more work for himself with the need to provide support for all these different trackers, Lewallen adds, he and his IT colleagues came up with the idea of doing one basic design that could be customized to serve the needs of different clinics.

Now, “instead of different designs, we have

tables that describe the [various] configurations, but all the patients reside in the same database,” he says.

“One clinic may want to have the appointment date and whether the patient showed up on time or not, another may want the physician’s name while radiology doesn’t want the physician listed,” Lewallen notes. “We just talk about which information they want displayed.”

The ED system, however, is “such a unique animal” that it must continue to be maintained separately, he says.

Versions of the patient tracker are in place at a number of UAMS locations, Lewallen says, including — in addition to those already mentioned — the ear, nose, and throat clinic; two areas that provide chemotherapy; and the pharmacy that supports both chemo rooms. Another 12 clinics, he adds, are in line to have trackers installed.

There is also the possibility of making the patient tracker available for use outside the UAMS environment, Lewallen says.

To those interested in developing a similar system, he advises “making sure the users do some really good research on what they want it to do,” asking themselves, “What is the data we need and how do we want to use it?”

Typically, Lewallen points out, what he is given as the basis for the design changes several times before completion. “We go back and forth, I give them the design, and they say, ‘Can you do this, too?’

“That’s fine,” he adds, “but the more research the users do [in advance] to provide to the designer, the better for both sides.” ■

the two systems to eliminate redundancy.

“We want to make the job easier,” says **Terry Lewallen**, a software developer in the UAMS information technology department who designed the patient tracker. “Right now [registrars] have to work in two different systems. We have an appointment system that the various clinics put their appointments into, and from that I get a ‘dump’ every morning and display those.”

When a patient presents in the clinic, he explains, the registrar has to find the patient’s name on the appointment list that has been cre-

ated, note the person’s arrival, and then activate the tracker for that individual.

“We’re waiting for a new appointment system to arrive,” Lewallen adds, “but our goal is that when [the registrars record] the person in that system, the information would be [automatically] sent electronically across the network into my system.”

Once the patients are checked in and entered on the tracker, Baldwin continues, they are taken by a patient care technician from the waiting area at the myeloma clinic to an area where vital signs are taken. When finished there, she adds, patients

are “checked out” on the tracker, and taken to an examination room.

“When a nurse sees [on the tracker] that a patient is in room 750, she goes into the room and does the initial assessment,” Baldwin says. “She checks in, indicating that she is there seeing the patient, so that [others] can see it on their screens. There is a little box that turns green. When she’s done, she checks out by pushing a button on the computer, which is the signal that the patient is ready to see the physician.”

Because the patient tracker is on the desktop computer of all physicians, nurses, and clinical research personnel who work in the areas where it is used, the physician can see from his office that the patient is ready to see him, she points out. When the physician enters the patient’s room, Baldwin adds, either he checks in on the tracker or a nurse does it for him.

If a research nurse needs to see the patient, he or she checks in after the physician checks out.

The length of time the physician spends with the patient — and the time that elapses during every other step in the process — is recorded by the tracker, Baldwin says. “It’s a great tool in terms of patient wait time, and [for documenting] when physicians complain that nobody has put the patient in a room.”

Before the system was implemented, patients might sit in the waiting room for up to two hours, Baldwin says, with staff not sure who the person was supposed to see or unable to find the physician.

“Once physicians know they are being measured, it’s amazing how efficient they are,” she notes. “They’re much more likely to maintain their schedule.”

The patient tracker also eliminates the need “to have someone running around saying, ‘Mr. X is in room 750,’” Baldwin points out. “It’s much better for the patient.

“One of the biggest problems we had before was the waiting, not knowing where the patients were,” she adds. “Now we know [immediately] when a room is empty.”

In addition to having the tracker in the clinic,

Baldwin says, it is also used in the chemotherapy room, where patients are assigned to chairs in which they receive treatment.

The “macro” aspect of the patient tracker is that it is designed to work not only in each clinic in which it is placed, but also to see if a patient is in an outside area — like radiology or the laboratory — and get an idea of when they will be finished.

Although Baldwin was just beginning to receive data on how wait times have been affected by the patient tracker, anecdotal evidence indicates they are dropping dramatically, she says. “Patients notice a big improvement.”

When six months’ worth of results are in place, Baldwin adds, she plans to present data to physicians and nurses to demonstrate what’s been happening. The length of time spent at various steps in the treatment process, she notes, also can be broken down by nurse or physician.

While patients typically don’t even realize the tracker is being used, Baldwin says, “staff really like it. It’s helped with the flow, synchronized things much better, and made it easier for nurses, physicians, and most of all for the patient.”

(Editor’s note: Betsy Baldwin can be reached at BDBaldwin@uams.edu. Terry Lewallen can be reached at LewallenTerryW@uams.edu.) ■

Patients properly placed as throughput streamlined

Unscheduled admissions targeted

An access initiative at Sutter Health in Sacramento, CA, is helping streamline throughput while placing “the right patient in the right hospital at the right level of care,” says **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health.

Part of the impetus for the project was an increasing number of one-day stays, which the

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health system's administration was "not thrilled with," adds Leach. The Centers for Medicare & Medicaid Services (CMS), she notes, sets a target percentage for one-day hospital stays by Medicare patients. The rationale, Leach explains, is that if a patient is only in the hospital for one day, the question whether the person might more appropriately have been given observation status, for example, or referred to a skilled nursing facility arises.

Another problem, she says, was that an increasing number of patients at Sutter's two acute care hospitals, which together have well over 600 beds, were not meeting InterQual criteria — a set of measurable clinical indicators, as well as diagnostic and therapeutic services, that reflect a patient's need for hospitalization.

"My personal driver was getting patients into the right status of admission," Leach says. "There is so much confusion, so much [area] that is gray, when an outpatient needs to remain for a longer period than normal because of unforeseen complications."

The first pilot project took place during the last week of June at Sutter General Hospital, she says, with a team composed of a case manager, a patient placement nurse already charged with assigning beds, and bed placement clerical staff who keep track of admission data and verify insurance eligibility.

"We live in an area where people change [insurance] carriers all the time, so one issue is determining whether a patient should even be admitted to this hospital," Leach notes. "We were often not finding out until a day or two later that someone was [taken] to another hospital. The other hospital calls and says, 'Thanks for providing open-heart surgery to our patient.' It doesn't take too many of those cases to feel like you're hitting bumps in the road."

Even if there is still the opportunity to transfer after a patient in another managed care plan is inappropriately admitted, she points out, "there is the disruption to the patient who has to move, and the expense to our hospital. We [incur the cost] of the most expensive day, and then we have to move the person to another facility."

Initiative focuses on controlling access

To hospital administrators, Leach adds, she emphasized the initiative's focus on controlling access so that only appropriate patients are admitted. To physicians, on the other hand, she

stressed that it would facilitate the admission of their patients.

While some hospitals have a similar process in place for planned admissions, she notes, the Sutter project was designed around unscheduled admissions, which are "our Achilles heel."

"For a week, we had all these people managing information," Leach says. "They verified that [patients] had appropriate insurance and they validated with information from physicians that patients met InterQual criteria for level of care — whether telemetry, intensive care unit [ICU], observation or inpatient."

Once the level of care was established, the patient placement nurse was asked if a bed of that type was available, she says.

In the past, Leach adds, physicians would call and say they needed a bed at a certain level of care, and staff would respond that it was available or not.

"We never knew [at that point] if the patient met criteria. Or, the [patient placement nurse] might say, 'I don't have an ICU bed, but can you take a telemetry one?' It might turn out that's what the patient needed anyway."

The project also has allowed dialogue with physicians in the emergency department (ED) — where there is a case manager — when patients don't meet InterQual criteria, she says.

"[The case manager] can say, 'The patient doesn't meet inpatient criteria, but maybe needs placement in an SNF, and I can help you with that,'" Leach continues. "Or she can say, 'The patient doesn't meet criteria, and in order to [admit at that level], we would need to do the following tests so we can escalate care.'"

That means, she adds, that when physicians admit patients and say they'll check on them later, the response now is, "That's not enough — we need a plan of care in order to move [the patient] along in the process."

Recognizing the conflict that could ensue from questioning physicians about their orders, she notes, staff choose their words carefully.

Instead of saying, "The patient doesn't meet criteria," and having the physician respond, "I don't care. Admit him anyway," Leach says, "We might call and say, 'We need to better understand the treatment plan so we can put the patient in the right place.'"

In the past, she adds, physicians simply would write the orders and the patient would be taken to the nursing unit. "We would have that dialogue [with the physician] 24 hours after admis-

sion when the case manager was doing the utilization review and would say, "Why is this person here?"

Inappropriate admissions avoided

As a result of the Sutter General pilot, Leach says, staff were able to identify a number of ED patients that otherwise would have been inappropriately admitted to the hospital and referred to outpatient treatment, place them in SNFs, or have them transferred to the facility designated in their managed care plan.

For all 51 patients admitted during the pilot — which was confined to between 8 a.m. and 5 p.m. — staff were able to document that they met the criteria for admission, she says. "That's not a huge number. We did this during a time when we were not getting slammed so we could work our process and have the necessary resources available."

By communicating with physicians, staff avoided admitting between seven and 12 people as inpatients, instead directing them to observation status or another type of care, she notes. "For example, physicians often will admit patients to the hospital for infusion, for hydration, but we have a clinic where that is done, so we can help set that up."

Apart from causing a financial loss to the hospital, Leach points out, she believes that inappropriate admissions are a quality-of-care issue. "The risks of being in the hospital — falls, medication errors, bed sores, infection — are all well documented. Those are all things that we are able to prevent if a person is not admitted unnecessarily to the hospital."

A pilot project at the health system's other hospital, Sutter Memorial, was a much bigger challenge, she says, because the majority of unscheduled admissions come through services other than the ED. That hospital, Leach explains, is located in a residential area and specializes in pediatrics, obstetrics, and cardiology. It is also a smaller facility than Sutter General.

"Cardiology patients often come through emergent admits from other hospitals or scheduled admits from interventional procedures such as heart catheterization or diagnostic imaging," she says. "We are dealing with specialists and with patients who are having procedures, not coming to the ED with a cold."

Because the patients being admitted may already be outpatients or may be coming from

another facility, Leach adds, it is easier to let them "slip through the cracks." During the Memorial pilot, she says, only nine people were admitted through the ED.

Although data from that pilot haven't been analyzed, Leach says, "we know anecdotally that we were very effective in the ED and that — even with the lesser number of admissions — probably impacted the same number of patients who were at the wrong hospital or needed to be hooked up with other services."

Hospital administrators initially were concerned that the steps involved in ensuring proper placement would delay patient throughput, she notes. "We provide tertiary care for multiple areas, so we have a specialty services network from all over California. We don't want to lose that business by putting up barriers to admission."

Those fears proved to be unfounded, Leach says, noting that in both studies, the length of time between a patient presenting at the ED or outpatient department and being admitted to the hospital did not increase.

In fact, the time may have been shortened, she adds, "but we don't have enough data to show that yet."

The goal is to have the kind of patient coordination done in the pilots in place around the clock, Leach says. "We'll probably be making decisions on [hiring] that person or people based on some volume studies. We use Navicare, which allows us to track all bed requests so we know the time from request to placement and all steps in between.

"We'll be tracking the periods when we need someone and when the nursing supervisor can manage it with enough InterQual training," she adds.

Sutter is in the process of training its current patient placement nurses on InterQual so they can ask those questions and be aware of the patients who stand out, Leach says. "My fantasy is to develop a transfer center where all of the steps of this process happen: Someone is dialoguing with the physician and potentially taking admission orders."

(Editor's note: Barbara Leach can be reached at LeachB@sutterhealth.org. Information about Navicare can be accessed by e-mailing info@navicare.net. Look for information on a throughput study focusing on cardiac patients and Sutter's 24/7 patient access coordinator in future issues of Hospital Access Management.) ■

JCAHO provides guide for emergency response

13-step process outlined

A step-by-step guide for small, rural, and suburban communities to prepare for and successfully respond to major local and regional emergencies has been issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Standing Together: An Emergency Planning Guide for America's Communities provides 13 essential steps that local government and public health leaders can use to establish an effective community-based emergency management planning and response process in the event of a hurricane, flood, terrorist attack, major infectious outbreak, hazardous material spill, or other catastrophic occurrence.

The guide offers a number of specific real-world examples of safeguarding data and systems in the event of a natural disaster, establishing links with federal and state mental health resources, ensuring culturally sensitive communication, and identifying appropriate planning partners.

Meanwhile, the Centers for Disease Control and Prevention (CDC) in Atlanta has released a report detailing the findings of a 2003 National Center for Health Statistics survey of hospitals regarding their preparedness for treating people injured in bioterrorism attacks or mass casualty incidents.

The survey of some 500 hospitals covered topics including emergency response plans, training for terrorism response, experiences with internal and external disaster drills, and availability of special equipment, such as decontamination showers, personal protective suits, and negative pressure isolation rooms.

Nearly all hospitals had emergency terrorism response plans and had revised them since Sept. 11. About nine in 10 hospitals were members of a regional interagency disaster preparedness task force, and three-quarters had key personnel trained to implement a formal incident command

Thirteen Steps In JCAHO's Emergency Planning Guide

1. Define the community.
2. Identify and establish an emergency management preparedness and response team.
3. Determine the risks and hazards the community faces.
4. Set goals for preparedness and response planning.
5. Determine current capacities and capabilities.
6. Develop the integrated plan.
7. Ensure thorough communication.
8. Ensure thorough mental health planning.
9. Ensure planning related to vulnerable populations.
10. Identify, cultivate, and sustain funding sources.
11. Train, exercise, and drill collaboratively.
12. Critique and improve the integrated community plan.
13. Sustain collaboration, communication, and coordination.

system, among other findings.

The CDC also has developed a "Keep It With You" personal medical information form for people who need care during disasters and similar situations.

The form is not intended to replace hard-copy or electronic medical records, the agency says, but as an interim communication tool "to assist individuals as they navigate a potentially complex system of temporary support, housing, and clinical services."

The CDC suggests that clinicians refine the form as necessary, and photocopy the document after an individual receives care to maintain a record of who was seen and what treatment was provided.

The original form is intended to remain with the individual during the time he or she is displaced, and can serve as an interim summary when normal care can be resumed.

COMING IN FUTURE MONTHS

■ More on registration kiosks

■ Using Six Sigma to reduce wait time

■ AR days slashed at surgical center

■ An update on regulatory concerns

■ Disaster strategies for patient access

More information on the report and the medical information form is available at www.cdc.gov. ■

NEWS BRIEFS

Care decision guides are available on-line

The American Health Lawyers Association has released a guide outlining the key legal and practical issues that arise in the care of individuals who face a life-limiting condition.

The resource provides key questions to guide families in making decisions along the continuum of care, and stresses that individuals should plan for the future and make informed choices now to ensure that their wishes are known at a future time when their physical and/or mental functioning may be impaired.

The guide can be read on-line or downloaded at www.healthlawyers.org.

The American Hospital Association (www.aha.org), meanwhile, has launched a national education campaign, "Put it in Writing," to encourage Americans to document their end-of-life preferences in advance directives while they are still healthy and able to make decisions. ■

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United States Postal Service				
Statement of Ownership, Management, and Circulation				
1. Publication Title Hospital Access Management		2. Publication No. 1079-0365		3. Filing Date 10/01/05
4. Issue Frequency Monthly		5. Number of Issues Published Annually 12		6. Annual Subscription Price \$199.00
7. Complete Mailing Address of Known Office of Publication (Not Printer) (Street, city, county, state, and ZIP+4) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305				Contact Person Robin Salet Telephone 404/262-5489
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305				
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Blank)				
Publisher (Name and Complete Mailing Address) Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305				
Editor (Name and Complete Mailing Address) Lila Moore, same as above				
Managing Editor (Name and Complete Mailing Address) Jill Robbins, same as above				
10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)				
Full Name		Complete Mailing Address		
Thomson American Health Consultants		3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305		
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box <input type="checkbox"/> None				
Full Name		Complete Mailing Address		
Thomson Healthcare, Inc.		Five Paragon Drive Montvale, NJ 07645		
12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one) The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: <input type="checkbox"/> Has Not Changed During Preceding 12 Months <input type="checkbox"/> Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)				
PS Form 3526, September 1998		See instructions on Reverse)		

13. Publication Name Hospital Access Management		14. Issue Date for Circulation Data Below September 2005	
15. Extent and Nature of Circulation		Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies (Net Press Run)		740	837
b. Paid and/or Requested Circulation	(1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. (Include advertiser's proof and exchange copies)	602	630
	(2) Paid In-County Subscriptions (Include advertiser's proof and exchange copies)	3	3
	(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4) Other Classes Mailed Through the USPS	7	19
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))		612	652
d. Free Distribution by Mail (Samples, Complimentary and Other Free)	(1) Outside-County as Stated on Form 3541	7	5
	(2) In-County as Stated on Form 3541	0	0
	(3) Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail (Carriers or Other Means)		25	25
f. Total Free Distribution (Sum of 15d and 15e)		32	30
g. Total Distribution (Sum of 15c and 15f)		644	682
h. Copies Not Distributed		96	155
i. Total (Sum of 15g, and h.)		740	837
Percent Paid and/or Requested Circulation (15c divided by 15g times 100)		95	96
16. Publication of Statement of Ownership Publication required. Will be printed in the November 2005 issue of this publication. <input type="checkbox"/> Publication not required.			
17. Signature and Title of Editor, Publisher, Business Manager, or Owner <i>Brenda E. Mooney</i>		Date 9/20/05	
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HHS says HIPAA rules allow Katrina information-sharing

Criteria include imminent danger to patients or the public

Within days of Hurricane Katrina lashing the Gulf Coast states, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) reminded providers through mailed notices and news media announcements that the privacy rule allows patient information to be shared to assist in disaster relief efforts and in providing patients the care they need.

The department said providers and health plans covered by HIPAA's privacy rule can share patient information in these ways:

- **Treatment.** Health care providers can share patient information as necessary to provide treatment, including sharing information with other providers such as hospitals and clinics; referring patients for treatment, including linking patients with available providers in areas where patients have relocated; and coordinating patient care with others, such as emergency relief workers or others who can help find patients appropriate services.

- **Notification.** Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for an individual's care. HHS said providers should get verbal permission from individuals when possible but may share information about people who are incapacitated or not available if it is their judgment that sharing information is in the patient's best interest. When necessary, a hospital may notify the police, news media, or public at large to the extent necessary to help locate, identify, or otherwise notify family members and others of the location and general condition of their loved ones. In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it isn't

necessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

- **Imminent Danger.** Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, consistent with applicable law and the provider's standards of ethical conduct.

- **Facility Directory.** Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, the person's location in the facility, and general condition.

HHS also announced a Section 1135 waiver that covered, among other things, sanctions and penalties arising from non-compliance with three provisions of the HIPAA privacy regulations — (1) the requirement to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of a facility directory; (2) the requirement to distribute a notice of privacy practices; and (3) a patient's right to request privacy restrictions or confidential communications.

In a later bulletin, the department expanded on its privacy rule compliance guidance for activities in response to Katrina and also explained how it would apply enforcement discretion.

That bulletin said that in addition to permissible disclosures by covered entities, business associates that are managing such information on behalf of covered entities may make disclosures to the extent permitted by their business associate agreements with the covered entities, as provided in the privacy rule. Thus, a business associate agreement may broadly permit the business associate to make disclosures the covered entity is

permitted to make, or may otherwise permit the business associate to make treatment or other disclosures as permitted by the privacy rule. If a business associate agreement does not permit such disclosures, the covered entity and business associate can amend the agreement to permit them.

Similarly if a business associate uses an agent to assist in performing its business associate functions, the business associate must ensure that the agent agrees to the privacy restrictions and conditions that apply to the business associate. The agreement between a business associate and its agent may also broadly permit the agent to make disclosures the covered entity is permitted to make or may otherwise permit the agent to make treatment or other disclosures permitted by the privacy rule.

Enforcement discretion being used

The department says the law provides that HHS may not impose a civil money penalty if failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period. The department has the authority to extend the period within which a covered entity may cure the noncompliance.

"We advise that in determining whether reasonable cause exists for a covered entity's failure to meet the business associate requirements and in determining whether and to what extent the period within which noncompliance must be cured, OCR will consider the emergency circumstances arising from Hurricane Katrina, along with good faith efforts by covered entities, their business associates and their agents, both to protect the privacy of health information and to appropriately execute the agreements required by the privacy rule as soon as practicable," according to HHS.

OCR also said it would not take enforcement action or seek civil money penalties in response to any complaints received involving use or disclosure of protected health information in the flood area if the release would have been permissible with a business associate agreement. It said if covered entities, business associates, or agents were unable to formalize agreements in time to meet evacuees' immediate needs but executed the agreements as soon as possible, there would be no enforcement action.

In another action with ramifications for

HIPAA, the federal government used prescription drug records provided by retail pharmacies to establish a database of Hurricane Katrina evacuees in eight shelters. The initial database included prescription information for more than 800,000 individuals located in 150 ZIP codes affected by the hurricane. Federal officials said they hoped to add electronic health records from pharmacy benefit managers, laboratories, Department of Veterans Affairs health facilities, and the Louisiana and Mississippi Medicaid programs.

This reportedly is the first time the federal government has used private health records from retailers to compile an electronic database. Although patient consent is not required when health records are shared for medical purposes, companies and organizations that possess such records must reach formal agreements before they can share the information with each other. But federal officials said they would not enforce the formal agreement requirement in this instance provided the companies and organizations reach verbal agreements to use the health records to help hurricane evacuees. ■

CMS no longer processing noncompliant claims

CMS: Compliant claims should reduce paperwork

Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan said the federal government will not process incoming non-HIPAA-compliant Medicare claims submitted for payment on and after Oct. 1, 2005. That decision ended a portion of CMS' HIPAA contingency plan that was in effect since Oct. 16, 2003, under which Medicare continued accepting non-compliant claims after the deadline.

McClellan reported that as of this past June, only some 0.5% of Medicare fee-for-service providers submitted non-HIPAA-compliant electronic claims. The highest rate of noncompliant claims as of May was 1.72% from clinical laboratories. Only 1.45% of hospital claims were noncompliant, and 0.45% of physician submissions.

"We are firmly committed to an interoperable electronic health care system, and the close to 100% compliance with HIPAA standards for claims shows that the health care industry shares this commitment," McClellan said. "Ending the

contingency plan for noncompliant claims makes sense. We'll be working with the noncompliant providers...with the goal of getting as close to 100% as possible" before the Oct. 1 cutoff.

The agency's contingency plan continues for other electronic health care transactions, but McClellan said he expects to end the contingency plan for those transactions as well in the near future. The remittance advice transaction is the next for which the contingency plan will end.

Important that claims be compliant

Agency officials said submission of HIPAA-compliant claims is a key element in streamlining processing of health care claims, reducing the volume of paper work, providing better service for providers, insurers, and patients, and cutting costs. Use of HIPAA-compliant claims allows the same software to be used to generate identical claims for all payers using standard formats and coding. Use of all the HIPAA transactions will allow interoperability among payers and providers for health care administration, the officials said.

The law required all payers to conduct HIPAA-compliant transactions no later than Oct. 16, 2003, but only about 31% of Medicare claims were compliant at that time. And other payers had even lower numbers of compliant claims.

To address the problem, CMS established a contingency plan that allowed its trading partners to submit claims in electronic formats currently in use. But the guidance implementing the contingency directed covered entities to make reasonable and diligent efforts to come into compliance and, in the case of health plans, to assist their trading partners to come into compliance. Contingency plans were not to be used indefinitely. ■

CMS issues risk analysis and management paper

Paper is sixth in a planned series of seven

The sixth in a planned series of seven HIPAA security rule educational papers deals with risk analysis and risk management. The rule's security management process standard has four required implementation specifications, including risk analysis and risk management.

According to CMS, both risk analysis and risk management are standard information security processes that are critical to a covered entity's security rule compliance efforts. Risk analysis and risk management are considered important to covered entities because those processes "form the foundation upon which an entity's necessary security activities are built," the agency says.

The security rule does not prescribe a specific risk analysis or risk management methodology. Rather, it gives the main concepts of the risk analysis and risk management processes and suggests that covered entities focus on the overall concepts and steps presented in the paper to tailor an approach to their organization's specific circumstances.

Examples of possible risk analysis steps are identifying the scope of the analysis, gathering data, identifying and documenting potential threats and vulnerabilities, assessing current security measures, determining the likelihood of threat occurrence, determining the potential impact of threat occurrence, determining the level of risk, and identifying security measures and finalizing documentation.

Ongoing processes

Once the analysis is complete, potential risk management steps include developing and implementing a risk management plan, implementing security measures, and evaluating and maintaining security measures.

According to CMS, as the foundation of a covered entity's security rule compliance efforts, risk analysis and risk management are ongoing processes that will provide covered entities with detailed understanding of the risks to protected health information and the security measures needed to effectively manage those risks.

"Performing these processes appropriately will ensure the confidentiality, availability, and integrity of protected health information, protect against any reasonably anticipated threats or hazards to the security or integrity of protected health information, and protect against any reasonably anticipated uses or disclosures of protected health information that are not permitted or required under the HIPAA privacy rule," CMS concluded.

Download the HIPAA educational paper at www.cms.hhs.gov/hipaa/hipaa2/education/ ■

HIPAA security rule progress still slow

Many companies still not fully compliant

A *Computerworld* survey of information technology managers and analysts found that five months after HIPAA's data security rules took effect, many health care companies still are not fully compliant with them. Those interviewed said technology, process, and budgetary issues delayed compliance efforts, along with what was seen as a weak enforcement component that has led many health care organizations to believe they could take a wait-and-see attitude toward the rules.

Meanwhile, a survey in June 2005 conducted by the Healthcare Information and Management Systems Society (HIMSS) showed that some 74% of the insurers and 43% of the health care providers responding to the survey said they were fully compliant with the security rules, which became effective April 20. Those numbers were up from the organization's January survey but still were surprisingly low to HIMSS officials.

Several organizations surveyed in June reported they had chosen not to implement all of the security requirements because they didn't anticipate that it would result in any image problems or legal issues, according to HIMSS Director of Informatics Joyce Sensmeier.

HIPAA provides for civil penalties of up to \$25,000 and criminal penalties of up to \$250,000 per year for noncompliance. The Centers for Medicare & Medicaid Services initiates enforcement action only in response to a complaint against a company. ■

Standards for claims attachments proposed

Proposed specifications from three organizations

The Department of Health and Human Services published in the Sept. 23 Federal Register a proposal for adoption of standards for certain attachments to electronic health care claims under HIPAA. The proposed standard would require doctors, hospitals, and other covered entities to use certain transactions, messag-

ing standards, and a new code set when they electronically request the additional information and provide the information in response to the request related to health plans processing claims.

"These HIPAA provisions make processing claims and other health care transactions much more efficient and, in the long run, save millions of dollars," said HHS Secretary Mike Leavitt.

The rule proposes specifications from three standards-setting organizations: two X12N transaction standards from the Accredited Standards Committee for requesting and responding with information; the content and format of communicating the clinical information from Health Level 7; and specific identification of the additional information being requested and the coded answers in response from the Logical Observation Identifiers Names and Codes, whose database is housed at the Regenstrief Institute at Indiana University.

Final rule expected in 2006

The electronic health care claims attachment standards will be effective within two years of the final rule's publication in 2006. They will work in conjunction with the HIPAA privacy and security rules. The agency set a two-month comment period.

"Setting standards for electronic attachments for the health care claims is a natural step in our goal of ensuring that clinical information be available when it is needed," Leavitt said. "These steps lead to a future in which electronic health records are complete and electronic medical record systems are beneficial." ■

HHS publishes interim final rule extension

The Department of Health and Human Services published Sept. 14 an extension to the interim final rule establishing procedures for imposition of civil money penalties on entities that violate HIPAA administrative simplification standards.

The interim final rule would have expired Sept. 16 but was extended to March 16, 2006, "to avoid the disruption of ongoing enforcement actions while HHS completes with rulemaking to develop a more comprehensive enforcement rule," the department said. ■

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Innovation, creativity increasingly important for advancement in access management

Technology expertise remains key

Health care organizations used to mention “re-engineering” expertise as they sought individuals to fill upper-level management positions, but now the operative word is “innovation,” says **Dee Hartung**, vice president in the executive search division of St. Louis-based Cejka Search.

“We’re seeing organizations wanting [candidates with] flexibility and creative thinking as they ask, ‘How can we innovate to make our processes better?’” adds Hartung.

As hospitals try to combine functions and leverage expertise, they are also looking for individuals who have skills across a number of areas, she notes. “We continue to get a number of requests to fill [director-level positions] that combine patient access, registration, and medical records functions.

“Along with that, we’re seeing increases in salaries,” Hartung says. “Previously, as a single function, a patient-admitting position might pay between \$60,000 and \$80,000, depending on the size of the hospital or if it’s a health system. Now we’re seeing salaries of over \$100,000 for those [multiple] functions.”

Her firm recently placed a director of patient account information at a large Midwestern hospital that was part of a national system at a salary of about \$120,000, she says.

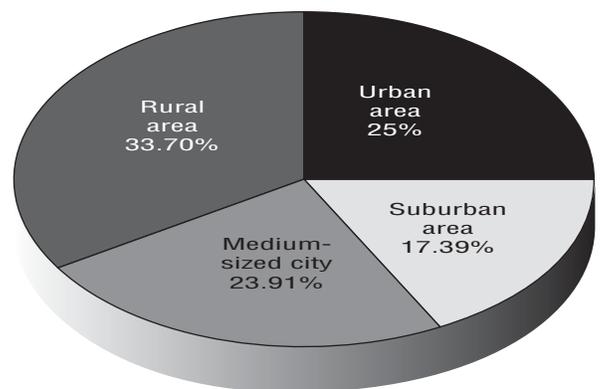
Advanced degrees are more important than ever

in securing those kinds of positions, Hartung suggests. “In every search we do, [employers] are looking for expertise and sophistication; people really believe that brings added value to the position.”

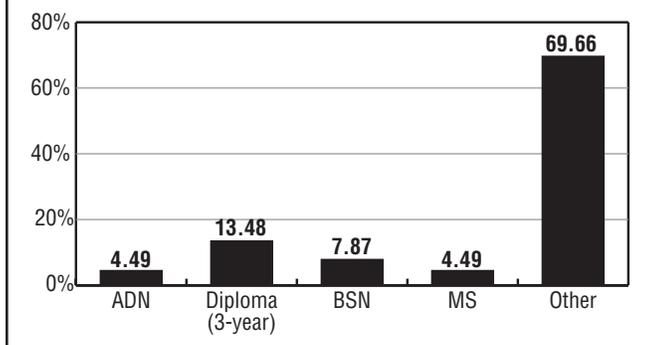
Her experience is that employers want those degrees to be obtained in the classroom, not over the Internet, and would prefer that if a person can’t go back to school full time, he or she get the degree by attending school in the evening or on weekends.

That degree typically could be a master’s in health care administration or some area of finance, or even an MBA, depending on the job emphasis,

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Hartung adds.

Hartung says she continues to find that in careers dominated by women — such as patient access — candidates are less likely to move for a job, but that the situation is changing.

“I’m working on a placement now for a director of risk management and compliance, a field where there are more women because the first degree is usually an RN, and the person goes on to get a master’s,” she says. “I’m delighted that we’ve identified several candidates who — along with their husbands — are willing to relocate.”

That position, Hartung says, is with a large medical group associated with a nationally known hospital, and will probably bring in a salary in the area of \$150,000.

Patient satisfaction strategies important

As health systems incorporate patient satisfaction as a key component in their overall strategies, notes **Pat Ahern**, a principal with Quick Leonard Kieffer, a Chicago-based executive search firm, the role of the access professional is expanding accordingly.

Organizations are looking for an access director with the skills to design the department to enhance patient, physician, and interdepartmental satisfaction, as well as to improve regulatory compliance and reimbursement, Ahern says. “[That director] will be more involved in training programs and in identifying technology that will advance and facilitate this process.”

Access directors also are increasingly involved with the public relations and marketing departments, as organizations begin to promote their services, she adds. “They will have a strategic view of the patient experience that other [department heads] do not. We have found that the higher-level [access professionals] do have those all-encompassing backgrounds.”

Ahern says her experience has been that salaries for a director of patient access management at a Midwest hospital range from \$85,000 to \$95,000, while a director with responsibility for more than one hospital might be paid between \$90,000 and \$125,000.

Bonuses for those individuals can range from 20% to 25%, she points out, particularly if they are involved in facilitating the implementation of a technical system.

“If somebody is serving as project manager for [a major implementation],” Ahern adds, “once the system is up and running, there can be a substantial bonus — 50% to 60% of the base salary.”

Technical expertise in combination with other skills remains a key factor in health care recruitment, agrees **Chris Cornwall**, president and CEO of Searchlight Recruiters Inc. in Laguna Hills, CA. “Salaries are going to continue to rise for people who understand and use technology in their jobs. There is a blurring of the lines between those who traditionally have managed the machines vs. those who collect the money.”

Organizations are investing more and more in technology, he says, “but they’re only as good as the people who know how to use that technology to better do the job.”

Consulting opportunities available

There remains a “tremendous need and opportunity” for experienced access professionals to work as contract consultants for service firms, says **David Borel**, managing partner for health care at the Atlanta-based firm PeopleSource Solutions.

That need remains, he says, even though the number of smaller, spin-off companies created by the leadership of the “Big Four” service firms has been somewhat reduced by consolidation.

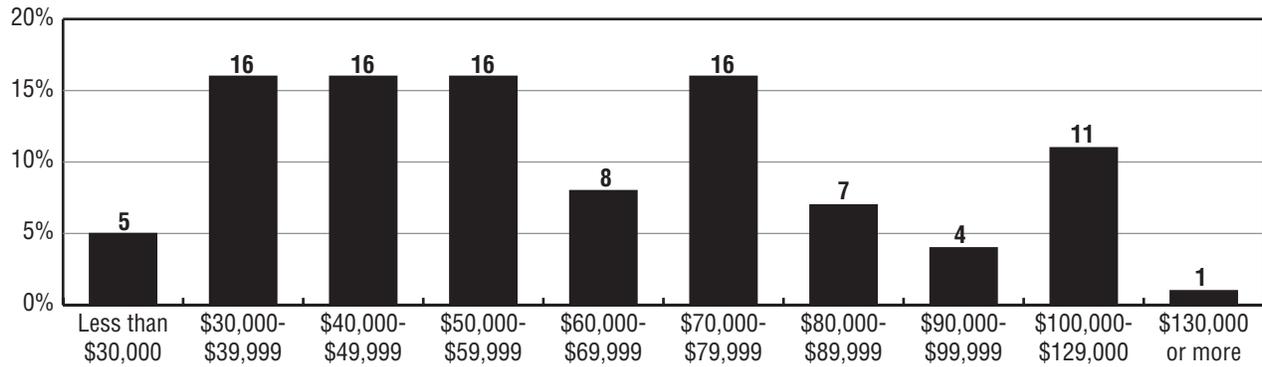
“I still think the opportunity is there and growing,” says Borel. “We’re looking at all levels, from ex-vice presidents to those with just a couple of years’ experience, to work on a contractual basis for these firms.”

Such a set-up, he notes, gives potential employees a chance to “try before they buy” and limits the firm’s risk of hiring a lot of people full time.

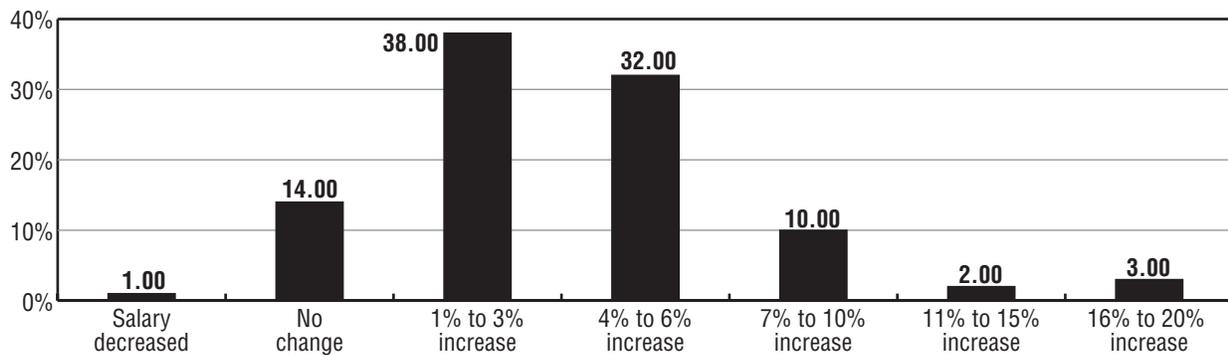
“Don’t be afraid to take contract or interim roles,” Borel advises. Not only do the hourly, weekly, or even monthly rates paid to contractors amount to more than the salaries of the firms’ full-time employees, he points out, “there is the

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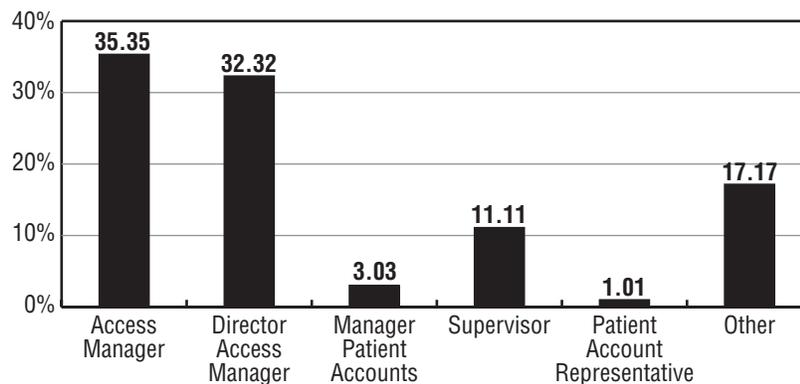
What is Your Annual Gross Income from Your Primary Position?



In the Last Year, How Has Your Salary Changed?



What is Your Current Title?



opportunity if you do a good job to roll over to another project, or to [be hired] full time.”

Unlike in the past, when independent contractors worked directly for hospitals and experienced the “feast or famine” syndrome, Borel says, there typically is no down time between engagements when working through a consulting firm.

“They’re doing the marketing for you,” he adds. “It’s to their advantage to get you out there.”

As for skill sets that will make a candidate particularly desirable in that arena, Borel says, “there’s a big push now regarding clinical throughput and how that correlates through the revenue chain.”

Survey breakdown

Access professionals responding to *Hospital Access Management’s* 2005 Salary Survey reported gross incomes that were evenly distributed among four salary ranges: 64% percent of respondents — or 16% in each income category — said they made between \$30,000 and \$39,900, between \$40,000 and \$49,900, between \$50,000 and \$59,900, or between \$70,000 and \$79,900.

Another 8% reported salaries of between \$60,000 and \$69,900, 7% put themselves in the \$80,000 to \$89,900 category, and 11% said they made between \$100,000 and \$129,999.

Five percent of respondents reported making less than \$30,000 per year, and just 1% said they made more than \$130,000 annually — the survey’s highest salary category.

The great majority of survey respondents said their salaries went up in the past year, with most

receiving a 1% to 3% increase (38%) or a 4% to 6% increase (32%). Another 10% got a raise of between 7% and 10%, while about 14% said there was no change in their compensation.

A handful reported substantial increases, including 2% who said they got a raise of between 11% and 15%, and 3% who received a 16% to 20% increase.

The most commonly selected job title — of five choices — was access manager (35%), followed closely by director, access management (32%). However, the next highest number (17%) chose the “other” category and listed a variety of similar, access-related titles.

Those included jobs registration and scheduling manager, admitting manager, director of patient registration, assistant director of patient access and patient access supervisor, admissions coordinator, and registration coordinator.

A couple of dual titles — senior director access services and chief privacy officer, for example — were listed, as were director of patient business services and regional director of access services.

Asked to give their highest academic degree, 13.48% of respondents chose “diploma (3-year),” 7.87% selected “BSN,” and 4.49% chose “MSA.” Almost 70%, however, said their degrees fit in the “other” category; included in that number were roughly 20% with master’s degrees, and close to the same percentage with bachelor’s degrees.

As usual, the vast majority (85%) of survey respondents said that “non-profit” best described the ownership of their employer, while the remaining responses were broken down between state, county, or city government (7.14%), for-profit (4.08%), and college or university (2.04%).

Almost 98% worked for hospitals, as opposed to “academic” or “clinic” settings, and most of those hospitals were in the Midwest and the South.

Respondents to the 2005 survey were more likely than last year’s report to work for hospitals in a rural area (33.70%), compared to an urban area (25%), a medium-sized city (23.91%), or a suburban area (17.39%).

Most of those taking the 2005 survey, just more than 70%, were between 41 and 60 years of age, with the heaviest concentration between ages 51 and 55 (20%), ages 41 to 45 (18%), and ages 56 to 60 (18%). Eleven percent were between 36 and 40, and another 9% were between 31 and 35.

It is no surprise that the gender gap in access management remains wide, according to the latest survey, with women representing about 85% of respondents. ■

