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IN THIS ISSUE

■ **Reimbursement:** Access department targets unbilled accounts . . . . . cover

■ **Patient placement:** Nurse validates insurance, level of care before admission 4

■ **JCAHO:** Access directors report little contact during recent visits 6

■ **'Tracers':** New survey method focuses on frontline delivery of care 7

■ **Customer service:** Accent reduction classes result of focus group concerns. 8

■ **Level of care:** Focus on cases you can impact, says veteran CM 9

■ **ED expansion:** Report links ED expansion with increase in uninsured patients 11

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Access department's CDM analyst is 'next step' to ensure clean claim

UPMC targets unbilled accounts worth millions

A newly created position at the University of Pennsylvania Medical Center-Presbyterian in Philadelphia is helping the access department take "that next step" toward reducing denials and ensuring proper reimbursement, says **Raina Harrell,** CHAM, director of patient access for business operations.

The "charge description master [CDM] analyst" position came about, Harrell adds, after the patient access department started working more closely with patient accounting to determine the reason behind a large number of reimbursement denials and rejections.

It became clear that, in many cases, accounts were being denied despite the fact that access personnel were doing everything right, she says, and that the problem was costing the hospital millions of dollars.

"We realized a lot of the rejections were secondary to the fact that we had issues in our CDM, which houses all of the charge codes and charges," Harrell explains. "When we bill, we have to make sure we use the appropriate codes, so we have software in place that flags the account and lets us know we won't get paid because a code is missing or [the account] is otherwise not up to the standards the payer will look for."

The codes change over time as the result of changes in government regulations and new services that need to be added, Harrell notes. "Many of the denials and rejections we were getting back were related to the CDM."

It's a given that the CDM should be examined at least every October, when the Centers for Medicare & Medicaid Services (CMS) updates the way that providers bill and what they need to bill for, she says, but there are also changes throughout the year — for example, when a new procedure is added.

When the hospital did an analysis of the accounts rejected by the software — or "claims scrubber" — that had not billed because of some type of revenue code or common procedure code (CPC) problem, Harrell says, it found a variety of CDM-related issues.

Revenue codes, she notes, are three-digit codes that providers use to describe provided services. "When completing the UB-92 [billing form], providers must describe the services related to the revenue code used." The CPC codes, Harrell adds, describe provided services, and are divided by CMS into three levels — physician services, non-physician services and supplies, and local codes assigned by local carriers and intermediaries when no national codes have been assigned for allowed services.

Among the unbilled accounts related to CDM issues were, for example, bills for a new service the radiology department had begun the year before, for which the codes had not been entered properly, she explains. "We fixed it, rebuilt those accounts, but we realized that as this happens in daily operations, we needed somebody on top of it.

"We looked at our open accounts receivable, and saw what was sitting there — more than 1,500 accounts, worth millions of dollars, waiting for fixes," Harrell says. "When we started to quantify [the problem] with our patient accounting department we said, 'This is not just a cleanup that needs to occur; this is something ongoing that needs to be done, or we will be in the same position a year from now.'"

The decision was made to create a new position, and to have that position lie within patient access, she says, "because we are the one department that connects with every other department in the hospital — radiology, laboratory, physical therapy — and we have responsibility for medical records." **(See related article in the April 2004 issue of *Hospital Access Management*.)**

A systems analyst in the access department was assigned to begin the CDM cleanup while Harrell and the rest of the access management team put together return on investment (ROI) projections for the new job, she notes. "In January 2005, we recognized there was a problem and started working on it, and by February, we knew there were CDM issues.

"We identified the problem in May, but we were so close to [the end of the fiscal year] that we put the position in the July budget."

There were some 1,500 CDM-related inpatient and outpatient unbilled accounts in January, Harrell notes, and by June, the number had dropped to less than 500 through the efforts of the system analyst. **(See graph, p. 3.)** "By April, we knew we needed a full-time person focused on the issue and would include the position in our budget [request]."

Using the 1,500 unbilled accounts, and the dramatic drop after the system analyst's intervention, she says, the access management team was able to put together an impressive ROI for the chief financial officer and other hospital administrators.

In addition to the one-time cleanup, Harrell adds, "we feel that 30% of what is out there [are problems] that will happen annually, so [the new employee] can make sure they don't happen every single year."

While the funding for the new position was approved in July, it was late November before the access management team found the right person for the job and brought him on board, she says.

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Editorial Questions

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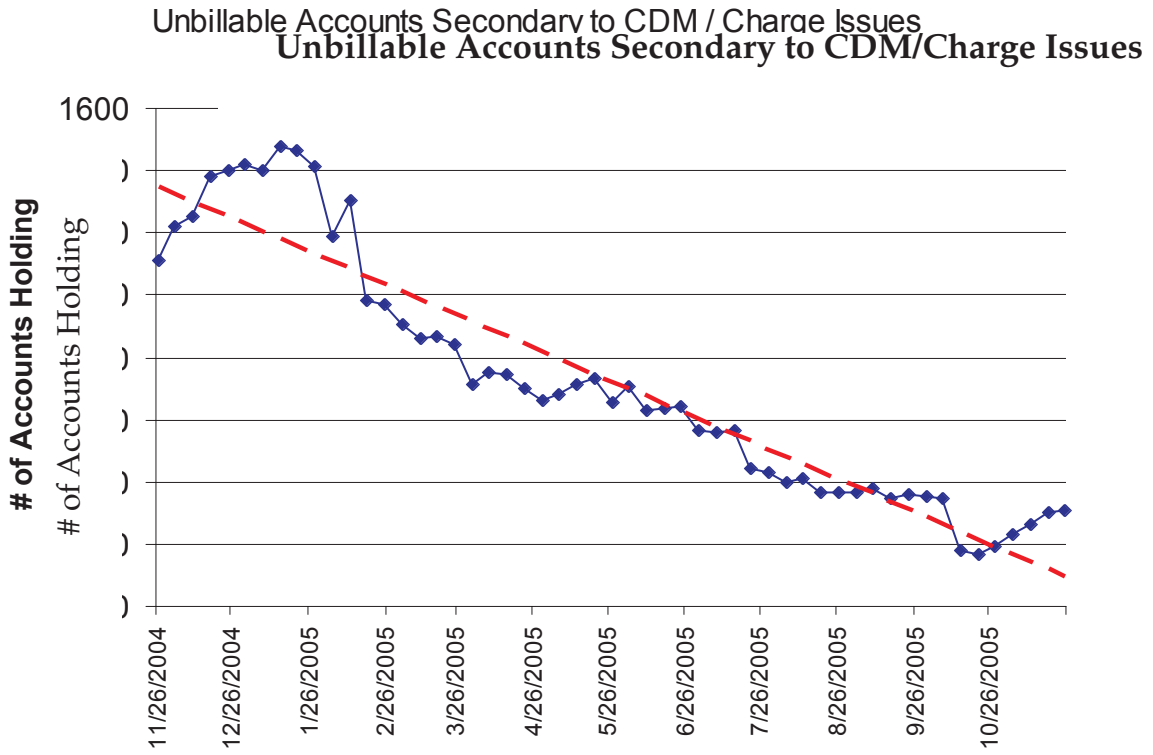

Source: University of Pennsylvania Medical Center-Presbyterian

The challenge, Harrell explains, was that the CDM analyst needed to have an understanding of billing and medical records coding, as well as some ancillary hospital experience.

"This person needs to be able to communicate with laboratory and radiology staff, and see things from their perspective," she notes. "He has to make [ancillary staff] understand that it has to do with their reimbursement, so he needs communication skills.

"Another part of what this person will do," Harrell adds, "is to work with administrators and say, 'This is what your CDM looks like now. Are you still performing all of these services? Is this the charge that should be associated with this service?' We're trying to do this preventively as well."

A certain amount of information systems knowledge is also required, she points out, because the person needs to understand how different parts of the computer system work and interact. "Sometimes there is a problem there."

After some fine-tuning of the job description so that it was "very specific as to what we were looking for," Harrell says, the position was posted internally on the health system's web site.

During the cleanup by the systems analyst, meanwhile, the identification of one issue in some cases cleared multiple accounts, Harrell notes, as with the new radiology service that had not been entered into the CDM.

Another example of "low-hanging fruit," she adds, had to do with charges that were entered late, so that the bill would drop before they were put on the account, resulting in a rejection.

Later in the process, there were "a lot of onesie, twosie issues," where the fix was a bit more complex, Harrell says. "It might be looking at, 'Did the operating room not enter a charge on the account?' or 'Did the person enter the charge on the wrong account?' The charge for the surgery is there, but the OR charge is not. Two cases might be missing a portion of a charge, but until someone looked at that account, it would sit there.

"For every procedure charge, there needs to be an OR charge, and vice versa," she notes, "and if the bill is missing one or the other, the [claims scrubber] will kick it out. Someone has to look and see what the problem is, and fix it."

The dollar value on each unbilled account ranged from $100 to $50,000, Harrell says. "We could have [a bill] sitting out there from oncology for a chemotherapy service that was rejected because there was a drug charge, but no indication how the drug was administered. The mechanism for getting the drug is not on there."

Drew Elliott, the person who was finally hired

as CDM analyst, Harrell says, came from the hospital's billing department, where as part of his job, he had looked at Medicare rejections. He had started work at the hospital years before in a clerical position, had entered charges in the past, and was familiar with all of the ancillary departments, she adds.

"He has the skills, and is already making hits for us [the first week on the job]," Harrell says. "Coming from patient accounting, he is better able to understand the comments from billers that were in the accounts, and go right to the departments and talk about what the problems were."

"In billing," Elliott notes, "I was looking at revenue codes and CPC codes — what was given to me — and now I have the opportunity to clarify what's given to billing. It's interesting looking at it from another perspective."

Once the CDM cleanup is complete, he says he will take a more proactive role — making note of new codes and updates and bringing them to the attention of ancillary departments "so we don't have to go back and forth with patient accounting."

"If there is a problem with a charge entered," Harrell points out, "he can go back and say, 'We had 10 accounts that didn't get an OR charge. How can we prevent this?' If radiology is doing a new procedure, [staff] will call Drew and say, 'Can you help us enter this new charge correctly?'"

It's particularly frustrating, she says, when access personnel "have jumped through all the hoops — preregistration, registration, precertification, insurance verification, copay all done properly — and somebody won't pay for it. So he can take that next step for us."

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Sutter access nurse targets unscheduled admissions

Insurance, level of care scrutinized

A patient access nurse charged with getting a handle on unplanned admissions at Sacramento, CA-based Sutter Health is working collaboratively with case managers and proactively with referring physicians to ensure proper patient placement.

"These [case managers] are nurses I can go to when dealing with cases that I think can go to a level of care other than acute," says **Barbara Kortes,** RN, who is stationed in the case management office at Sutter General Hospital, where an initiative begun in June 2005 as a pilot project has been extended to all adult services at both hospitals.

At Sutter General and at the organization's larger facility, Sutter Memorial, a patient access nurse has been designated to streamline the admission of unscheduled patients, while at the same time controlling access so that only appropriate patients are admitted.

Working in the same office, Kortes notes, has made it easy to ask case managers about cases in which, for example, it appears that a patient might be headed toward inpatient admission primarily because the family is burned out from providing care at home. "They're available to review the case, [to say], 'Is it a placement issue? Might we be able to put the patient in a skilled nursing facility?'"

Now that her role has expanded, Kortes says, "there is even more learning and education that goes on."

As a tertiary care provider, Sutter General receives frequent referrals from outlying hospitals, she notes. "Our goal was to try to provide a system that was more user-friendly, a one-stop shop," Kortes adds. "Sutter recognizes that there were multiple ways to access the system, and felt it was important to [reduce that] to one or two numbers. We've worked hard to have any requests funneled back to the patient access nurse."

In the past, a physician at another hospital who wanted to refer a patient to a Sutter specialist would call that physician directly and say, "'Let me tell you about my patient,'" says **Kate Tenney,** RN, manager for case management at Sutter General. The receiving physician would OK the transfer and someone would call the patient

access nurse to let her know the patient was coming, she notes. "We would find out the next day that the patient's insurance plan is contracted with another facility or with a county program that won't pay, and that the transfer shouldn't have happened."

Now the nurse is checking insurance and health plan status, consulting InterQual criteria for level of care, and questioning referring physicians *before* a patient is admitted, adds Kortes.

If the patient being referred is coming from another facility's emergency department and says that he or she is a Sutter patient, she says, "we're validating that information. If it's a Medicare patient who needs to have a procedure that the [referring] facility can't do, we're asking if the person can go to another facility [affiliated with the referring hospital]."

In the case of a patient who needs emergency care that can't be provided by the referring facility, however, "we're under regulations not to ask any questions, but to provide that care if physician and bed are available," adds Tenney. "If the patient is already stabilized, we're free to ask more questions, but we're very careful to make sure we're meeting EMTALA requirements."

In some instances, Kortes explains, the first call regarding an unplanned admission comes to the bed control office, based in the business services department, where clerical staff take down the initial information — diagnosis, admitting physician, contact number, and the type of bed (inpatient or observation, for example) that is being requested.

"At that point, I get notified, and I call the physician back and review the case with him," she continues. "I also have access to patient records on-line, and at that time I will try to get a quick history — whether the patient was here last week, or whether we've never seen the person before. It gives me more information when I'm talking to the physician."

Meanwhile, Kortes says, she is using the InterQual reference manual to determine if the patient meets observation or inpatient criteria, and at the same time asking the physician questions about things such as the person's current blood levels, which tie into those criteria.

If the criteria for inpatient status are met and that is what is requested, she adds, there is no reason to mention that, but if she believes the patient is better suited for observation status, Kortes makes that suggestion. "My experience has been that [physicians] are very receptive."

At that point, she puts in a request to the nursing unit, the charge nurse assigns the bed, and Kortes makes the call back to the physician. The patient comes to the hospital lobby to register or, if too ill to do that, goes directly to the room, she adds.

"At the same time, I'm also doing a quick insurance test," Kortes says. "The physician will say the patient has Medicare A and B, and we're validating that, and also that the person should be coming to Sutter. If that is not the case, I'll be notified by the bed control department, and will let the physician know that the insurance plan is aligned with another health care system and the patient needs to be admitted there. It's really simultaneous."

The other way that a call for an unscheduled admission can come in, she notes, is through a call from the physician's office directly to the patient access nurse. "As we develop a relationship with the physicians," Kortes adds, "we have a pager number that becomes more established, and they call us directly at either of the Sutter hospitals, depending on the services needed."

Sutter General specializes in neurology, oncology, and orthopedics, she says, while Sutter Memorial's focus is on neonatal care, cardiac care, pediatrics, and women's services.

Each time a case is handled successfully by the patient access nurse, the program's success "builds on itself," notes **Danielle Corcoran,** RN, Sutter nursing administrator. "We're seeing the physicians being much more open. As the patient access nurses become more knowledgeable, [the physicians] are searching out their knowledge. I believe they see [the nurses] as friendly, accessible, and a resource."

At present, Kortes says, she and her counterpart at Sutter Memorial, with relief from a third nurse, perform the patient access duties seven days a week, 10 hours a day, except for two weekends a month. During those weekends and after hours, she notes, the patient access pager is answered by the nursing supervisor, who does the job in addition to her other duties.

There is a budget request in to have a fourth nurse, which will allow 12-hour coverage, seven days a week, Kortes says. "In our busiest times, we want to have a nurse to work just on the placement issues. We're looking to extend our hours into evening."

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Access gets little action in recent JCAHO surveys

'Tracers' target front line, not bosses

Access directors at two facilities recently visited by surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reported little or no contact with surveyors, and an overall experience that was decidedly different from previous visits.

Those accounts reflect the dramatic change in the survey process that took place in January 2004, says **Joe Cappiello,** BSN, MA, vice president, field operations, for the Oakbrook Terrace, IL-based organization. At that time, surveyors began doing "tracers" — picking up the trail of certain patients and following the course of their care through the facility — as opposed to setting aside blocks of time to talk mostly with hospital leadership.

The new process, he adds, eschews formal checklists and chart reviews in favor of discovering "a sense of the way [hospitals] conduct business day in and day out."

Since JCAHO surveys are a triennial event, two-thirds of all the accredited facilities had been surveyed using the new method by the end of 2005, he says, and the remaining third will experience it in 2006. The latter facilities also will be exposed to another innovation that has some hospital leaders on edge — the unannounced visit. **(See related story, p. 7.)**

At Wake Forest University Baptist Hospital, the admitting department prepared extensively for the JCAHO visit, says **Keith Weatherman,** CAM, MHA, associate director of patient financial services, but had virtually no interaction with surveyors.

"I personally had no contact," he adds. "However, [a surveyor] did walk in to an outpatient area and talked to one of the registrars — asked what her role was and how long she had worked here."

In his past experience with JCAHO surveys, Weatherman says, he was typically called upon to set aside certain times to be available for meetings with surveyors. During this visit, he notes, there were few such formal encounters.

What Weatherman did observe about this year's visit, he notes, is that surveyors were particularly concerned with whether the necessary consents were obtained from patients.

Surveyors also wanted to know whether caregivers asked patients what their primary language was, Weatherman says, and were very interested in how advance directives were handled.

"Another thing I noticed was that they were making sure that signatures were legible," he adds. "There were a couple of charts where the bar code label with the patient's information might have covered part of the signature, and they didn't like to see that."

In anticipation of the JCAHO survey, Weatherman says, his department made sure that policies and procedures were updated, and set up displays showing departmental goals, as well as the organization's focus on the Six Sigma quality assurance methodology.

"We had 'Joint Commission Jeopardy,' and gave prizes if, for example, employees knew who the [hospital's] safety officer is," he notes. Despite what might have seemed like preparation overkill in view of a JCAHO visit that barely touched his department, Weatherman says he hasn't changed his philosophy.

"If anybody reads this and thinks they're off the hook, I wouldn't advise that [attitude]," he adds. "If it were going to happen again, I'd still make sure we were well prepared."

One of the more humorous accounts of the Wake Forest survey visit, Weatherman recalls, came from the human resources department, where the manager had taken great care to ensure that some 6,000 employee folders were in perfect order.

"[The surveyors] only asked for one chart," he says. "We have a clinical dog for the geriatric area, and they wanted to make sure its shots were up to date."

Privacy notice highlighted

One of the "couple of phone calls" from JCAHO surveyors fielded by **Holly Hiryak,** RN, CHAM, director of hospital admissions, during the agency's recent site visit to the University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock had to do with how her department handles distribution and documentation of the HIPAA privacy notice.

That process, she explained, is documented electronically in the registration system so access staff can track whether or not a given patient has received the notice. The electronic documentation has been in place since about a month before the Health Insurance Portability and Accountability Act's privacy rule became effective on April 14, 2003, Hiryak adds.

"If, for instance, a patient is seen in the outpatient clinic and it is the person's first time there, there is a required field that has to be populated," she says. "If there is nothing in that field, the frontline staff will know [the privacy notice] has never been provided."

At that point, the registrar gives the patient the privacy notice, asks the person to sign an acknowledgement form, and then puts the indicator in the field, Hiryak says. "Then we don't ever have to do it again, unless something changes with the form."

If the patient's first encounter with UAMS is a telephone interaction, the registrar triggers a "mail request," she notes. At midnight, the computer system automatically prints the notice, and then mails it out the next day, Hiryak adds.

The system, meanwhile, changes the designation in the field to "mail sent," she says. "If the patient returns the [signed notice], we scan that in and indicate that it was received."

The JCAHO surveyors also checked with Hiryak — as part of the process of doing tracers, or following certain patients through the different phases of their hospital encounter – to make sure that the Consent for Treatment for those individuals was in place, she notes.

Otherwise, there was no interaction with the access department, Hiryak says. "[The surveyors] didn't stop and talk with my staff at all. From our standpoint, [the visit] was no big deal."

Overall, UAMS Medical Center did very well on the survey, she adds. "What they told us was that for a hospital of our size and complexity, the average number of recommendations for improvement was between nine and 14. We had only six, and we received an unconditional accreditation."

[Editor's note: Keith Weatherman can be reached at kweather@wfubmc.edu. Holly Hiryak can be reached at HiryakHollyM@uams.edu.] ■

JCAHO gets praise for new survey style

Surprise visits start this year

Two years into using the "tracer methodology" of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to survey accredited facilities, the agency is receiving "a constant stream" of positive feedback, says **Joe Cappiello,** BSN, MA, vice president, field operations, for the Oakbrook Terrace, IL-based organization.

"They're saying, 'Finally, you have got it right. This is where the rubber meets the road,'" he adds. "It's about the delivery of patient care."

In addition to marking the exposure of the final third of JCAHO facilities to the new methodology, Cappiello notes, 2006 also heralds the beginning of the agency's unannounced visits.

"Only those scheduled to be surveyed in 2006 are going to be exposed to the unannounced process [this year]," he says. "If you're due, it's going to be done in 2006, but if the anniversary of your last visit is December, we might do you in February."

Hospitals are allowed to provide JCAHO with a number of "blackout dates," which the agency will honor, Cappiello says. "If you know that May 4-6, you're going to have an emergency preparedness drill, or that on Aug. 9, you will have a medical staff retreat, those are not good times for us to be there."

But he points out that "care goes on 24-7, and the CEO, director of nursing, and medical director are not always there, so what does it matter if we arrive when some of the leadership is not present?"

Then and now

Before 2004, JCAHO surveyors developed an agenda for each hospital visit, with blocks of time set aside to be in certain areas, Cappiello explains. "We might be in unit 9G from 9 a.m. to 10 a.m., and then go to the emergency department from 10 to 11. Included were the obvious places — the ED, the operating room, any site where anesthesia is administered — and then a sampling of the general units of the facility."

Hospital leaders were alerted to be on hand for several formal sessions, and there was much questioning about policies and procedures, he says. Staff, meanwhile, did things like write "the top 10 questions surveyors will ask" on the back of their hospital badges, Cappiello notes.

Now the blocks of time are allocated for tracers, whereby "between 15 and 18 patient charts, at an average-size facility" are pulled, and the course of those patients' care is followed through the hospital, he says.

Before going to a facility, the agency develops a profile of the facility that suggests where to start the tracer, Cappiello notes. "This is publicly accessible information based on codes [the hospital] submits to the Centers for Medicare & Medi-

caid Services, and based on its accreditation history, sentinel events, complaints, and various sources we have available. So we are being directed by the data toward certain units or certain services."

At the beginning of the survey, he continues, surveyors ask for patients who are in-house or recently discharged from those units or services, and then randomly select some charts. "We actually follow the path of those patients."

If the data suggest a look at the cardiology service, for example, surveyors might come across the chart of a Mrs. Lopez, who came to the hospital via the ED after a 911 call to which paramedics responded, Cappiello says. "Maybe she got a number of diagnostic tests — a scan, radiology, cardiac catheterization — and winds up where she is today, in the cardiology unit."

Surveyors might go to the point of entry, the ED, and, if possible, meet with the staff that took care of Lopez a few days before, Cappiello adds. If they're not available, surveyors will go to other ED employees — "not management, but those directly administering care."

"We'll say, 'Tell me how you would manage a person who is 50-plus, overweight, on a number of medications, brought in by ambulance, and complaining of chest pains,'" he continues. "The nurse might respond, 'We have a cardiac protocol, etc.,' and that begins to lead us down a path of questioning."

While talking with the nurse who took care of the patient, surveyors might take note of the fact that Lopez spoke only rudimentary English, and ask the nurse how she communicated with her, Cappiello says. "We're not trying to make a judgment on clinical delivery of care, but to understand whether the staff is competent in their ability to care for the patient and all of her special needs.

"Are they prepared, are they adequately trained? Do they have the necessary knowledge and experience, and are they caring in a way that ensures a good outcome and protects her dignity?"

Surveyors will follow the patient's course to the bed she is currently in, Cappiello says, continuing on to radiology, for example, and asking staff about their care of Lopez, or someone like her: "What training did they receive? How do they care for the equipment?"

As patients travel through a medical center, he points out, "they literally come into every part of our standards. So we don't have to go down a checklist. All we have to do is follow that course and talk with the staff and management that have surrounded the patients in their travels."

Asking about access

Going back to the example of Mrs. Lopez, Cappiello says, "it may very well be that her admission was done in the ED by access staff who will have to communicate with her, understand what her source of pay is, etc."

While in the ED discussing her care, he adds, surveyors may notice an access employee admitting a person in a nearby cubicle, and decide to follow up on those registration issues, and talk to frontline staff about how they do their job.

"The beauty of this is, there are no trick questions," Cappiello says. "If we engage someone from access, we will ask them how they do their job, and how well they were prepared to do the job." ■

'Accent reduction' class gains kudos for hospital

It's part of patient-centered care

"Accent reduction" classes at Swedish Covenant Hospital are giving employees who speak English as a second language the chance to improve their communication skills while helping the Chicago-based facility fulfill its commitment to providing patient-centered care, says **Joanne Shearer,** RN, MSN, director of educational programming.

Located in one of the most culturally diverse areas of Chicago, Swedish Covenant cares for a patient population that represents more than 40 different languages, and has a work force that reflects that diversity, she adds.

"We heard from focus group discussions with former patients and from physicians that it is difficult to understand some of our patient-care staff due to language pronunciation issues," Shearer says. "Out of that feedback, we decided to look into accent reduction classes."

The focus groups, she notes, are one of the things the hospital does, in part, because of its affiliation with Planetree, a nonprofit Derby, CT-based membership organization that promotes patient-centered care.

Truman College, a community college with which Swedish Covenant has partnered in the

past to bring college credit courses onto the hospital campus, happened to have a class in accent reduction, Shearer says, and so the decision was made to offer it onsite.

"We asked for volunteers to take the class — it was not required and was free to employees — and we promoted it as a positive opportunity that would help them at work and outside work," she says. Hospital officials were aware, Shearer notes, that some employees might be reluctant to acknowledge their need for the class, and that approaching staff about taking the class might be uncomfortable for some managers.

"We wanted to be very sensitive to that, but it was more of a potential barrier than something that actually occurred," she says. "We just [addressed it] through communicating with managers, and then they approached the staff."

The 20-hour course was generally covered in 10 two-hour sessions, held between 4 p.m. and 6 p.m., Shearer says. While several different foreign languages were represented — the most common being Spanish, Korean, and Russian — the instruction was customized to take that into account, she adds.

"The trainer was good at helping a person with, say, a Korean background, on things to work on [specific to] that language," Shearer says. "There were 10 to 15 people in each class, and they will take 20 at the most. There is a fair amount of individual work with the students."

Based on an assessment tool with a scoring range of 1-24, there was an average change in score (improvement in pronunciation) of +5, with the greatest increase in score by a participant being +12, she says. The average pre-class score was 17, and the average post-class score was 22.

In recognition of the accent reduction class, Shearer notes, Swedish Covenant received the Planetree Best Practice Award in the category of human interaction.

Two courses were held in 2005, and plans were to continue the class in 2006, she says, possibly once each quarter.

Feedback from the first course helped generate interest — and gain volunteers — for the second, Shearer says. "We had some managers who participated, and that helped, because they talked about it when they went back to their areas."

[Editor's note: Joanne Shearer can be reached at (773) 878-8200, ext. 5687.] ■

Veteran CM keeps focus on cases he can impact

Set priorities, refine reports, he says

At the busy Massachusetts General Hospital emergency department, which sees between 200 and 250 patients a day, case manager **Peter Moran,** RNC, BSN, MS, CCM, says his focus is always on these questions: Why is the patient here? Why is the patient being admitted? What needs to be done, and is there a possibility it can be done in a [less acute] setting?

"If you can move them," he adds, "what are the barriers to getting them out? Some clearly can go home, some clearly need to be admitted, but the struggle is to identify cases where case management can have an impact."

One of the things that has the biggest payoff in terms of answering those questions in a timely and effective manner, Moran says, is to quickly identify patients who have the potential to be moved. One target, he notes, might be those who are on Medicare and who have had a three-day stay in the hospital within the past 30 days.

"Patients who meet those criteria and who are found not to have an acute medical condition can be moved directly from the ED to a skilled nursing facility [SNF]," Moran says. "The key is having the correct information."

Another trigger might be certain diagnoses, he points out, noting that a lot of chest pain cases, for example, can be put on observation status, depending on whether the patient has a history of heart problems — and a lot of payers want them in that designation. If the correct designation occurs up front in the ED, Moran says, claims can be processed and paid more quickly, with fewer denials.

One problem with finding the cases in which one can have a measurable impact, Moran continues, is that it's difficult to identify these patients without picking up every chart and scanning it — something that's difficult to do in a busy ED.

Mass General is in the process of implementing a faster way to identify these patients, he notes, through a report run off the information system it uses for utilization review, which also has a case management component.

He suggests that case managers develop a list of the types of patients they want to target and determine if reports can be generated based on

certain diagnoses, repeat visits, or "whatever the [case management] program is aiming to impact."

"Try to use the systems you have," Moran says, "but sometimes the information you want is not found in a standard report. A lot of us have systems that are not state of the art, so you need to create special reports."

Although Mass General is still fine-tuning its new report, it has been helpful, he adds. "When I come in, it's not unusual for me to have 15 or 20 people waiting for admission. If I see someone had a Medicare admission and discharge within the past 30 days, I look at those charts first."

On the other hand, if someone comes in and is definitely going to be admitted, that case is not a priority, Moran says. "With certain payers, you can't move a patient [to another level of care] without pre-approval, and that will impact how I prioritize certain cases.

"For example, I know for a fact that with Massachusetts Medicaid, I need pre-approval to send someone to an SNF or rehab facility," he says, "so if a patient comes in over the weekend, and if he can't go home, that's a patient I cannot impact — he will be admitted. I can do an initial assessment, I can identify where the patient would like to go and I can have the patient screened, but I know I can't get approval until Monday."

Complicating the process, Moran notes, is the fact that most EDs are "getting overwhelmed with geriatric and mental health [cases]. The patients are getting older, and a lot of them are alone.

"We're also starting to see more people who are primary caretakers who need to be admitted to the hospital," he adds. "When they get hospitalized, what happens to the person they are caring for? If the 92-year-old [patient] has been taking care of a mentally impaired person, who is now 64, is there a way we can arrange for someone to take care of the dependent? Can we mobilize family members or community agencies?"

If not, Moran notes, such patients will frequently present to the ED and may become "social admissions" — patients who have no acute medical needs but who are not safe to discharge.

During the hours of 9 a.m. to 7 p.m., when case management services are available, there is time to see only so many patients, he says. "I'm being used for the person who is in the ED because he or she had a fall, is frail, elderly, and lives alone, and for the homeless and uninsured populations."

In addition, Moran says, he is consulted by physicians and families looking for assistance in caring for chronically ill people at home.

In looking at whether the person is fit to go home, he points out, he must consider what the person's baseline is: "How are they managing? What services are in place? So many are chronic — they're at home on a banana peel anyway — the question is, 'Is [the current condition] different, or is this their baseline?'"

Meaningful measurements

One question that needs to be addressed, Moran says, is whether information systems are measuring the work that case managers are actually doing.

"We've had an ED case management program since 1995," he notes, "but it became apparent that the information we were collecting was not necessarily what we wanted to have, so we sat down as a group to talk about what we want.

"We had a report that was capturing the number of patients referred to SNFs and to rehab, and the cases where we had to arrange for assistance with medications and were involved with getting transportation, but the job has evolved over time.

"We can say that the nurse saw the patient and that he went to rehab," Moran adds, "but would that have happened anyway? What was the impact of the case manager?"

Moran says he receives calls from case managers across the country who want to discuss their experiences in ED case management. "Some say their programs failed, some say they were successful, but I always ask them the reason they are putting case management in the ED," he notes. "There are so many things we can spend time on. How are we going to evaluate the impact of having the case manager there, and does everyone understand why we're doing what we're doing?"

The key, he emphasizes, lies in recognizing the problems that a specific institution is trying to address. "Some have low capacity — they won't try to divert patients if they can get them admitted and be reimbursed for the care. Or the purpose of putting [a case manager] there may be getting those coming in for primary care hooked up with a clinic appointment.

"When people say they want to create an ED case management program, I say, 'OK, but how [is the institution] going to measure the success or failure of your program?'"

He recently spoke to a case manager at a county hospital in south Texas, where there is a shortage of physician specialists, Moran says. The problem, he adds, was that people were told to come to the ED to get services, and then the expectation became that the case manager would arrange for specialty follow up.

"There were no more positions, just this added responsibility," he says. In such cases, Moran advises, case managers need to be able to document that — while this is not a typical case management function — it is a major problem in that location that they are trying to solve.

"It's an institutional priority," he adds. "It may not be what [case managers normally] do, but it is what they want the program to do, and it takes a great deal of time."

Moran says he told the caller — who was frustrated at not having the coverage to perform this task along with more usual case management work — to say she was willing to do the specialty follow up, but hospital leadership must realize she might not be able to do something else. He also suggested that she do a study showing how much time the specialty work entailed.

"I now advise people that whatever the program, they must know its purpose, the institutional goal, and how to measure success and failure," he says. "You can get pulled in 30 different directions, and they're all important, but you have to prioritize.

"You must be able to say, 'I'd love to help you, but I need to do this.'"

[Editor's note: Peter Moran may be reached at pmoran3@partners.org.] ■

Report links ED expansion, increase in insured patients

Growing pressures also cited

Given the high rates of admission through emergency departments, having a large or full-service ED is one way to ensure a steady flow of insured inpatients and make a hospital appealing to clinicians and patients, according to a recent report from the Center for Studying Health System Change.

With that in mind, the report states, many hospitals in the 12 U.S. communities visited during the study are expanding or renovating their EDs. These improvements are being made despite success in reducing ambulance diversions via more efficient management of patient flow from admission to discharge and enhanced emergency services coordination, the report says.

In general, ED expansions appear to be motivated by competition for well-insured patients, particularly in affluent locations, the report goes on to say, an occurrence that was particularly notable in Indianapolis, Miami, northern New Jersey, Phoenix, and Seattle. However, the study notes that some safety net hospitals are renovating, in part, to attract more insured patients.

ED directors and hospital CEOs cited changes to architectural appearances and patient flow, increased numbers of beds, decreased waiting times, and greater use of state-of-the-art technology as examples of improvements being made.

Another development at some hospitals that has improved flow through the ED is the creation of adjacent admissions units. Staff transfer patients from the ED to these units as soon as the decision to admit has been made. Once in the admissions unit, the initial set of clinical orders can be carried out, including lab testing, radiology services, and drug administration, if necessary.

In some sites, the report states, respondents indicated that these various efforts have already increased rates of insured inpatient admissions.

The report also addresses what it describes as growing pressures on hospital EDs — from persuading specialists to provide on-call coverage to dealing with an increasing number of patients with serious mental illness — and says these factors could compromise access to emergency care and add to rising health care costs.

The rising pressures are a result of larger forces throughout the health care system, includ-

COMING IN FUTURE MONTHS

- Bed management changes hands
- Strategies for staff training
- AR days drop for surgical center
- Another access career ladder
- More hurricane/ access lessons

ing financial incentives that reward specialist physicians for performing more procedures outside general hospitals, diminishing access to primary care, and declining funding for community-based mental health services, the study indicates. ■

Cost called impediment to broader IT adoption

While nine out of 10 hospitals are using or considering using health information technology for clinical uses, most cite cost as a major impediment to broader adoption, especially for small or rural hospitals, according to a recent survey by the American Hospital Association (AHA).

The survey results suggest that the use of health IT in caring for patients is evolving as hospitals adopt specific technologies based on their needs and priorities, size, and financial resources. While most are still in the beginning stages, the survey shows hospitals are making investments in IT, in large part, to make gains in the safety and quality of patient care.

Some of the technologies and systems hospitals are using include bar coding devices, computerized physician order entry, and electronic health records. ■

Broader use of EHR pushed in CHT report

The Center for Health Transformation has released a report outlining recommendations for spurring adoption of electronic health records based on the successful practices of health data exchanges known as regional health information organizations (RHIOs).

The report calls on Congress to pass "comprehensive" health IT legislation this year that includes grants or loans to create RHIOs and removes regulatory barriers to health IT progress. The center advocates dedicating 1% of federal discretionary spending, or roughly $7 billion a year, to health IT, which it calls vital to reducing medical errors and increasing disaster preparedness. ■

Final rule published on electronic claims

The Centers for Medicare & Medicaid Services (CMS) has published a final rule on electronic submission of Medicare claims under the Health Insurance Portability and Accountability Act, identifying the circumstances for which mandatory submission of electronic claims to the Medicare program is waived.

The rule, which became effective Dec. 27, 2005, essentially adopts the provisions set forth in the August 2003 interim final rule and ends the contingency phase for electronic submission of claims under the HIPAA transactions standards that took effect Oct. 16, 2003. ■