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Hospital enhances patient placement with switch in bed control oversight

Preadmit tracking, electronic bed board system are key

Improvements in communication and placement strategies gained by moving bed management oversight from the admitting department to nursing are facilitating patient throughput at Wake Forest University Baptist Medical Center, says **Jonathan Morris,** RN, bed management coordinator for the Winston-Salem, NC, facility.

A new preadmit tracking and electronic bed board system has greatly enhanced the process, adds Morris, who was hired as a "bed czar" in May 2003, in part to bring that system into being. **(See screen page, p. 15.)** The gradual implementation of the system, completed in November 2005, has enabled the medical center to consistently meet its goal of assigning a "clean, ready bed" to 96% of unscheduled patients in less than two hours, he notes. **(See graphs, p. 17.)**

"When we started collecting that data — how long it took from a request to the point we were able to assign a clean bed — [that percentage] was in the mid to upper 80s," Morris says. The improvement happened even before full implementation was achieved in November, he says, because his staff began using the new computer program "a few steps at a time" in December 2004 while still handling bed requests over the telephone.

"We did a pilot using the post-anesthesia care unit [PACU] and two nursing units — one medical and one surgical," Morris explains. "We used that pilot to look at each step in the process — "right click here, left click there" — so we would know how to take the request from the PACU and the best way to funnel it to the receiving unit."

While using the new computerized system "to the [highest] degree possible, we were still taking requests by phone," he adds. "As we turned around and called the units, we were also pretending we were doing [the same steps] in the system, so we could look at any glitches."

The idea, Morris says, was for his staff to fine tune the process before beginning to train other nursing personnel. "We looked at, 'Who will do what? What will my staff do? Do we have the information we need with-

out talking to someone? Is there a step we missed or is this an interface issue?' We did that for a couple of months before bringing up [other units]."

Before he assumed the bed coordinator role and the tracking system was implemented, Morris says, "bed control for this 821-bed inpatient facility was strictly pieces of paper." A month after he came on board, an admissions nurse who reported to him was hired, he adds, and a little more than a year later, in July 2004, bed control officially was moved out of admitting and into nursing.

The location of the bed management area — next to admitting — stayed the same, "but the reporting structure and focus has changed," Morris notes. The idea behind the switch, he says, was that a nurse would be more adept at the process, from the perspective of triage and level of care.

Changes in status to a higher or lower level of care — both at the beginning and during an inpatient stay — happen more quickly and easily because of the increased clinical focus, Morris says. "Before, we might have beds in some locations that would not be used because it was ingrained in the workflow of the [previous bed control employees] that this was a hands-off area."

In some instances, however, it is appropriate to use oncology or cardiac beds for patients coming from the ED, he says, and employees with a clinical focus are more comfortable making those exceptions.

"With oncology [bed occupancy], there typically are peaks and valleys," Morris notes. "A lot are scheduled, and you can almost predict [the number of beds] you will need."

Bed management staff with clinical training also are aware of any medical implications — the kinds of non-oncology patients who are appropriate to place on an oncology unit, for example.

"Prior to me and some other clinicians coming in, the thought process wasn't there. It was, 'I can't go into that unit — I have to make the patient wait.' They were pretty much black and white, and health care [decisions are] so gray. You have to think."

While the majority of his staff are still non-clinical, Morris adds, "we've worked hard on educating them, explaining the thought process behind why we do what we do. There is a lot of open dialogue."

Bed management staff are now better able to communicate with the hospital's nursing units, he says, and, if necessary, obtain reports from outside facilities to better enable patient placement, although that function is typically handled by nursing.

Another benefit of the increased clinical focus, Morris says, is that nurses are able to "proactively communicate with physicians as to why we're doing what we're doing, to alleviate any backlash from the medical staff."

In the past, physicians often suspected that their patients couldn't get to a unit because nurses were "hiding" beds until the next shift, he adds. "It's practically impossible now to hide a bed with the systems we have in place, because they're all connected."

As for feedback from physicians on the improved process, he ascribes to the no-news-is-good-news theory, Morris adds. "To me, a

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Editorial Questions

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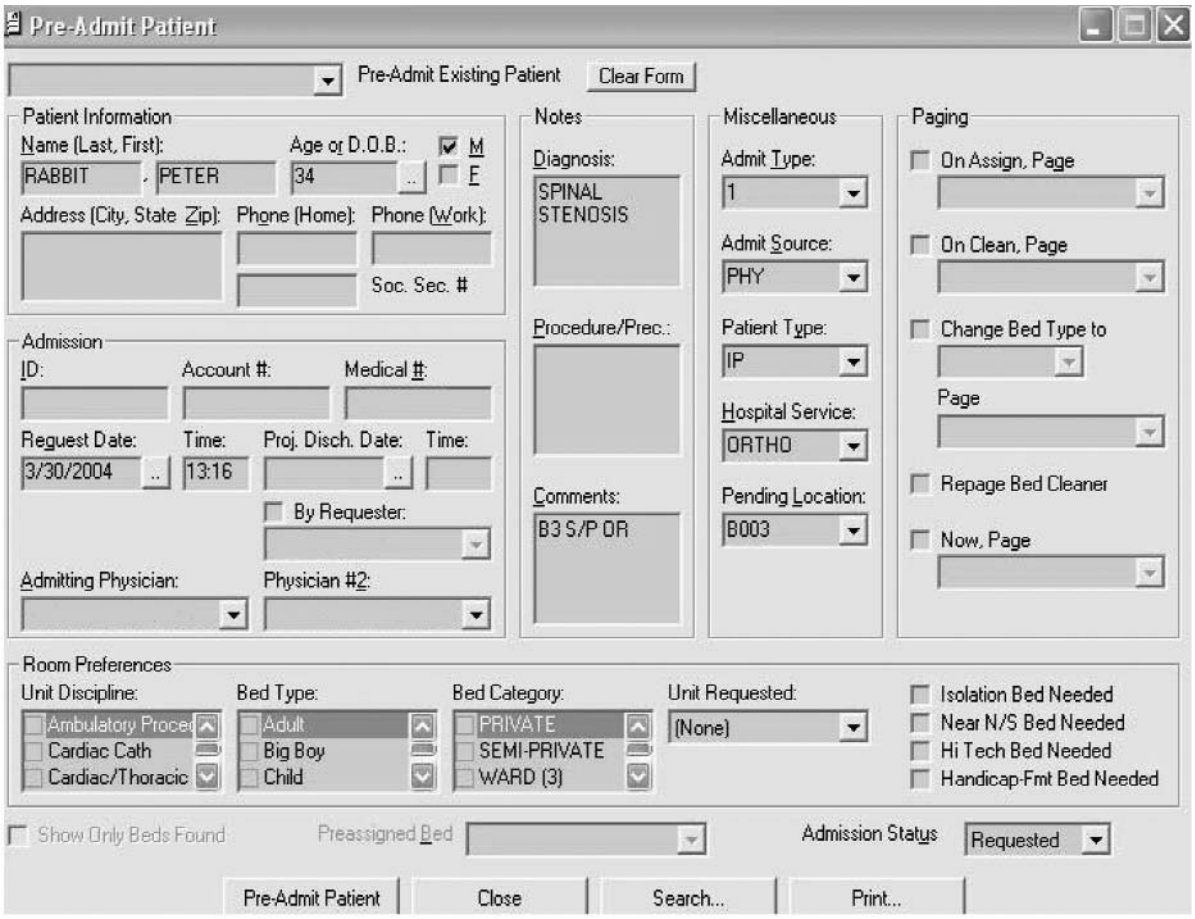
Example of Preadmission Screen



Source: Wake Forest University

positive [reaction] from a physician is not hearing a negative. When I first took this role, there were a number of complaints — not only to nursing administration but to hospital administration — about patients being scattered on different units and about bed crunch issues. There has been a decrease in that."

General medicine practitioners, in particular, he says, had complained about their patients being spread out on multiple units, while cardiologists contended that there were "too many non-cardiac patients using [cardiac beds] for telemetry."

In response to those concerns, the department developed algorithms to establish "cluster units" — grouping surgical units and medical units based on medical specialty, Morris says. "There were slight algorithms in place before, but they were not as intense."

To further address the situation, the hospital has added more telemetry beds on the medical units, he says. Not having to move a patient to another bed at the same level of care to free up a telemetry bed — for another patient who may be waiting in the ED — saves valuable time and improves patient flow, Morris notes.

Real-time viewing

With the preadmit tracking system and electronic bed board, he says, staff are "able to visualize every single unit and every bed in real time — whether it's clean, dirty, occupied — and it's all done through interface activity with our main frame."

That "biggest improvement" has resulted in many other improvements, Morris notes, including the ability to "time stamp" to determine where backups are occurring and to do process-time analysis with the ED and the neonatal intensive care unit [NICU] to determine "how we're doing from a patient flow and patient throughput standpoint."

The sequence of events, he explains, is as fol-

lows: "We electronically page the nursing unit and funnel a request, and they have a 10-minute time frame to assign a bed. When they assign the bed, the requesting unit or area will be notified by electronic page that the bed has been found, and will see in real time if the bed is clean or dirty, waiting to be cleaned."

The process has "truly eliminated all of the telephone tag and the 'he said, she said'" conversations about assigning blame, Morris says. "This puts everybody on a whole new honor system."

The bed management department has four other registered nurses in addition to Morris, he says, as well as 13 clerical employees, some full time and

ED, discharge units improve patient flow

LWOS numbers down

As bed management coordinator at Wake Forest University Baptist Medical Center in Winston-Salem, NC, **Jonathan Morris,** RN, has been indirectly involved in creating an emergency department (ED) holding unit that has been successful in reducing the percentage of patients who "leave without being seen" (LWOS) — a commonly used measurement to monitor customer service.

The 10-bed holding unit was initiated at the end of 2003, Morris explains, to improve ED throughput by accommodating patients still being screened for various conditions, or waiting for inpatient beds.

The unit is designed for patients awaiting a clinical decision or "rule out," he says. "We don't put higher level of care patients in there.

"It's hard to say what helped the most, between [the holding unit] and coming on the preadmit tracking board, but [the ED] is now below the national average for percentage of patients who leave without being seen," Morris notes. Formerly between 4% and 6%, he adds, the hospital's LWOS rate is now 2% or below.

The verdict is still out, Morris says, on a recently opened discharge holding unit, another initiative aimed at enhancing patient flow. The unit — open four days a week, 10 hours a day — is for patients who have discharge orders written, he adds.

"They might be waiting for home health supplies or medication from our pharmacy to be delivered, or just for a ride home," Morris explains. "Many of our patients live two or three hours away."

Those who meet discharge criteria are transferred to the unit, which is located on the main floor of the hospital, next to the area where family members drive through to pick up departing patients, he says.

The discharge holding unit provides another way to use the electronic bed board, Morris notes. "It shows pending and confirmed discharges on the units. Nurses in the discharge unit have access to this, so they can police it to see where these discharges are located. They will call the [nurses on the unit] and remind them."

This proactive approach is part of "pulling" the patient to the next step in the throughput process, rather than "pushing" from the previous location, he says. "The old way was [for unit nurses] to hold off [on moving the patient out] because there is all this other stuff to be done."

His belief is that the receiving unit — for example, a regular unit due to receive a patient from the intensive care unit — should offer to go and get the patient if time allows, Morris says. Traditionally, he notes, it has always been the transferring unit's responsibility to take the patient to the next location.

Financial discharge area added

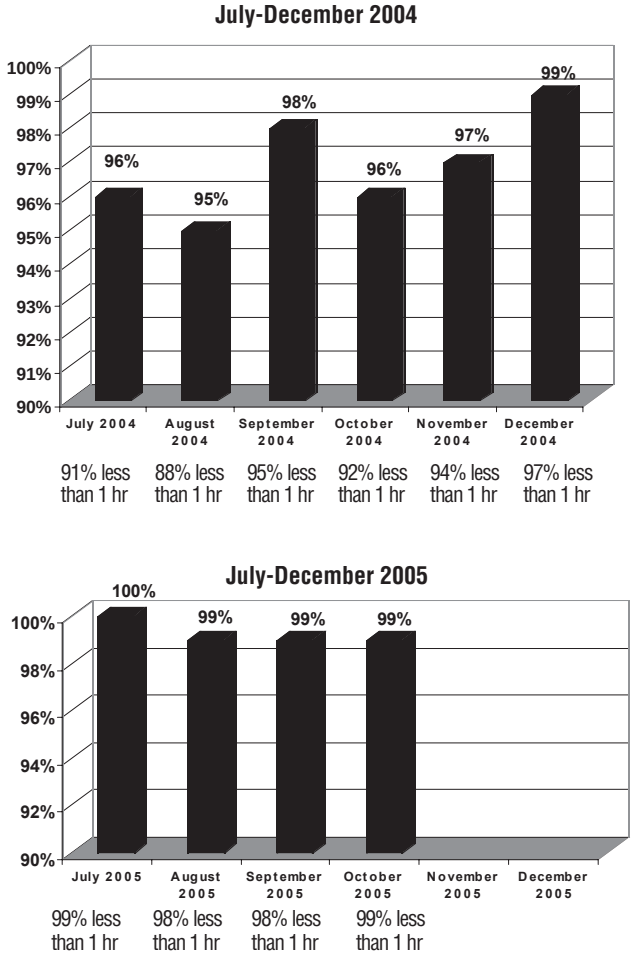
In addition to the new clinical discharge area, points out **Keith Weatherman,** CAM, MHA, associate director for patient financial services, there is a new financial discharge area, located nearby. The idea is to offer financial counselors the chance to get a last piece of necessary information, he says, as well as to provide the opportunity for patients to pay the liability portion of their bill before they leave.

Financial counselors' hours have been adjusted, Weatherman says, to accommodate the new discharge station, which is open until 7 p.m. It is under the supervision of the manager of financial counseling, who also oversees ED registration, he adds.

"It's been a great patient convenience," Weatherman says. "We have collected money in that area, rather than waiting until statements go out." ■

Wait Times for Bed Placement

Bed Request to Placement
Wait Times Assigned/Clean Bed Less Than 2 hr



Source: Wake Forest University

some part time. "We operate 24-7 — we don't close down and let the ED take over [after hours]."

There was also 24-7 coverage when the function was overseen by the admitting department, Morris notes, but while day shift employees were designated for bed management, after-hours staff performed other admitting functions in addition to bed control.

When the switch was made, he adds, the number of full-time-equivalents (FTEs) that had been allocated to the admitting department for bed control were shifted to his department. Another 1.7 FTEs were added, Morris notes, to make up for the after-hours employees, who remained in admitting.

There was some resistance to giving up control of the function from admitting employees who had worked in bed management for many years — for a manager to whom they were very devoted, says **Keith Weatherman,** CAM, MHA, associate director for patient financial services. "Traditionally, bed control has been a part of admitting, and it was hard for them to give that up. We had a lot of meetings and got their buy-in."

During the same period, the admitting department was in the process of assuming responsibility for three outpatient clinics, he notes, which opened up new job possibilities for those employees.

With some of the experienced bed management employees moving into clinic positions, Weatherman adds, it became even more important for the admitting manager to work closely with new bed management staff during the transition.

"The nursing staff that came on board had to learn the admission/transfer/discharge [ADT] system, how to do transfers and assign beds in the computer, and perform some census [functions] at night," he say. "It was not a clean break. [Admitting personnel] were involved in the process from the time it began in July 2004 until November 2004."

In addition to the benefit of enhanced clinical communications, Weatherman points out, the change in bed management oversight is appropriate because of changes over the years in the way hospitals do business.

"At one time, bed management needed to be in patient access because there were rate differences for private rooms," he says. "Years ago, Medicare reimbursement was for a semi-private rate. [Finance staff] might have to collect the difference from a patient who wanted a private room or, if the person was put in a private room because a [semi-private room] was not available, they would have to do a write-off. Now, with a predominant room rate and reimbursement according to diagnosis-related groups, it's a whole different ballgame."

Some hospitals have moved not only bed management but the entire access department under nursing, Weatherman notes, which he believes "hurts on the finance side. It doesn't have to be all or nothing."

A side benefit of the Wake Forest reorganization for him personally has been the removal of bed control-related issues from his department's jurisdiction, he says. "Before, there were phone calls that I — and even the director and CFO — would get that were about bed control questions. Now we can concentrate on patient access, patient finance, AR [accounts receivable] issues."

Transport tracking is another feature of the bed

management software suite, which is a product of Pittsburgh-based Teletracking Technologies, he notes. This tracking device for medical center transporters — who wheel patients down to the discharge area, for example, or to radiology for a scan — interfaces with the bed tracking and preadmit tracking/electronic bed board functions, Morris says.

"[Transporters] get a page from the response center giving them a number to call," he explains. "They dial in and get a computerized message saying, for example, 'Room so and so needs discharge with a cart.'" The system, Morris adds, automatically locates the closest idle transporter.

The transporter accepts the job by dialing into the system, he says, which logs in the transporter and tracks his or her time and productivity.

When the transporter is ready to leave the unit with the patient, he uses the house telephone or the phone in the patient's room to call in and report that he is in progress, Morris says. "If it's a discharge, the system flags that bed as dirty, and we automatically see it. Before, we were solely dependent on nursing to send down the information to us."

In the past, it was not uncommon to get notice of a discharge "two or three hours after a patient had left the building," he notes. "When the shift ended, [unit nurses] would put in all of the discharges, and the next shift would get hit [with handling them].

To ensure that the system continues to run smoothly, he follows up regularly with unit managers and directors, Morris says, to make sure that unit secretaries and staff are actually putting the pending and confirmed discharges into the system.

"It's a wonderful system, but it is a computer," he points out. "It's only as good as its users."

(Editor's note: Jonathan Morris can be reached at jomorris@wfubmc.edu. Keith Weatherman can be reached at kweather@wfubmc.edu.) ■

'Survival skills' honed in continuing ed initiative

Outgrowth of customer service course

When Mt. Graham Regional Medical Center conducted a successful customer service course — encompassing not only its own staff but community members and health care workers from outlying facilities — the effort led to yet another initiative, aimed at enhancing employee morale and teamwork, says **Julie Johnson**, CHAM, director of health information management, communications, for the Safford, AZ, facility.

The customer service course, "Together to the Top," is a four-and-a-half-hour program that covers 12 service standards **(see box, p. 19)**, with the overarching themes of compassion, integrity, and excellence, Johnson notes. "It's about how to treat our patients, visitors, families." The course attracted outside attention, she adds, when Mt. Graham board members and employees who had taken it began talking about it out in the community.

When the 59-bed hospital received calls from Safford city officials, who were looking for a customer service program for their employees, and management of the Morenci (AZ) Health Care Clinic, which is located 50 miles away, Mt. Graham's response was to provide the course to all who were interested — free of charge, Johnson says.

The offer is typical of Mt. Graham's community-mindedness, she explains, which may have something to do with its increasingly rare status as an independent, locally owned hospital that — despite its relatively small size — apparently has a large presence in its 100-mile service radius.

The customer service course began in 2001, and 65 classes had been completed by the end of 2005, Johnson says. "They are now held every other month for all new employees and those who would like to attend the course again."

The hospital is preparing to open a state-of-the-art cancer center — an event recently celebrated with a visit from bicyclist and cancer survivor Lance Armstrong, Johnson says. The cancer center is being built with large picture windows facing nearby Mt. Graham, she adds, which is the inspiration for the customer service theme, "Together to the Top."

All of the hospital's initiatives, Johnson explains, are designed to fall under Mt. Graham's guiding principle — "Toccare Lo Spirito," a Latin phrase that means "To Touch the Spirit." **(See related article in the next issue of *Hospital Access Management*.)**

After the completion of a recent customer service course, the hospital did a survey of its employees "to see what still needs to be fixed," Johnson says. "[Survey results] showed that what needed to be worked on was interdepartmental relations; we weren't treating each other very well."

That realization led to another project spearheaded by Johnson — who also conducted the

customer service course and aimed at enhancing leadership and team-building skills, she notes. The chief operating officer (COO), the admissions supervisor, the quality/foundation secretary, a coder, and the hospital's concierge also were involved in presenting the resulting two-hour program, Johnson says.

It was decided that the new program would be based on "Survivor," she explains, when project organizers kept coming back to the theme of "surviving the everyday interactions that occur."

"We then decided that this would be a series of classes to be held every two years as a 'refresher' course," Johnson adds, with the topic being whatever issues come up as needing to be addressed. "These continuing courses will be based on feedback from the employee surveys that will be implemented every other year."

Over a six-month period in 2005, 45 "Survivor" classes were held, and a similar schedule is anticipated for 2007, she notes.

'Basic Service Standards' in Mt. Graham course

1. Treat the people we serve as guests. Be courteous, make eye contact, smile, introduce yourself, and address people by name whenever possible.
2. Present a professional image. Apparel and appearance are appropriate, neat, and clean, with name badges highly visible.
3. Answer the phone with a "smile."
4. Listen to the people we serve and our coworkers, respond promptly and reliably to the needs of our customers.
5. Anticipate the wants and needs of the people we serve.
6. Work to effectively communicate with patients, families, and each other.
7. Keep the people we serve informed about their care and treatment.
8. Maintain a safe, clean environment.
9. Act to reverse negative service situations using the "Anticipate, Acknowledge, Apologize, Amend" (4A) process.
10. (HIPAA) Respect the privacy and confidentiality of the people we serve.
11. Strive to master the skills needed to do your best for the people we serve.
12. Positively represent our facility in the workplace and in the community. ■

The program had a kind of "Pirates of the Caribbean" motif, with treasure hunts, drums beating, and decorations that included gold coins, tiger cloth, leopard skin, and huge butterflies, Johnson says. "Our theme was to become committed to each other."

The entire staff, she adds, from housekeeping employees to board members, took part in the program.

As the first step to discovering how to relate to others more effectively, Johnson explains, participants learned about themselves. An underlying idea, she says, was that no matter what position a person holds in the organization, every one is called upon — at one time or another — to be a leader.

"We focused on leadership being a function of knowing yourself, or having a vision you can communicate," Johnson says. Using the acronym of SELF, she adds, participants looked at themselves in terms of whether they were socializers, executives, lovers or fact-finders.

"We did something you don't normally do — we put people in categories," Johnson says. "Actually, we let them do it themselves, by saying, 'If you're an introvert, come here, and if you're an extrovert, go there.' We had everyone in four corners."

Each person talked about himself or herself, saying, for instance, "'I am a socializer' or 'I am a risk-taker,'" she adds. "They also talked about limitations. The risk-taker might also be overbearing, restless, dominating, for example. Each group talked about what their characteristics were."

In some sessions there were no fact-finders or executives, but — as might be expected in a health care setting — there were always lots of lovers, Johnson points out. "Everyone put themselves in the category they would be in anyway. Fact-finders tended to be maintenance or security or financial [personnel]."

As part of the exercise, people in each group listed their likes and dislikes, she says. "Executives might like control and responsibility, while lovers like teamwork, caring, kindness. Fact-finders like perfection and consistency."

"One of the fact-finders said he absolutely did not like a meeting when a memo would suffice," Johnson adds. One lesson learned was not to take up time with chit chat or pleasantries during a phone call to maintenance employees, but to get right to the point, she says. "That's what they want."

The COO told other participants the story of

how, when he was first getting to know Johnson, he would walk into her office and immediately launch into the item of business he needed to talk with her about, she recounts. "I would say, 'My weekend was really great, thank you very much.'"

His realization was that the same sort of thing was going on interdepartmentally, Johnson says. "Everyone learned how to connect with the other people according to how they categorized themselves, and how to be realistic and flexible about expectations. They learned how to communicate up, down, and across."

(Editor's note: Julie Johnson can be reached at juliej@mtgraham.org.) ■

GUEST COLUMN

Providence uses Six Sigma to reduce patient wait time

'Data are the cornerstone'

By **Rebecca Coplin**
Director, Seamless Access
Providence Health System
Portland, OR

(Editor's note: In the first segment of a two-part series, Rebecca Coplin, one of 15 Providence managers chosen to participate in an intensive Six Sigma training course, discusses the infrastructure the organization has in place to ensure process improvement. In next month's issue, Coplin describes two access initiatives aimed at simplifying the registration process — centralized preregistration and check-in kiosks — that are receiving high praise from patients.)

In keeping with our service-oriented mission and our core value of excellence, Providence Health System has made significant investments in people and training, the keys to lasting process improvement.

In 2002, Providence began a journey with Six Sigma. Six Sigma is a logical, data-driven, statistical approach to identifying problems, implementing solutions, and maintaining positive results. While the principles of Six Sigma have been used for decades in manufacturing, only recently have they been applied to health care.

Fifteen of our managers were invited to participate in a rigorous six-week training course taken over the span of six months. Each trainee selected a project on which he or she could practice the Six Sigma framework. One project selected was to reduce wait times for outpatient services, such as unscheduled labs and X-rays. **(See flow diagram of project's scope, p. 21.)**

A project team was assembled and we quickly realized accurate wait time data were not available. Anecdotally, we knew patients were frustrated with the wait but we couldn't monitor or report on the magnitude of the problem.

Because data are the cornerstone of Six Sigma, a manual data collection process was established. Once wait times were measured, we surveyed patients to understand their expectations. Patients told us they expected to be registered and waiting for their service within five minutes. Our average wait time was more than 10 minutes.

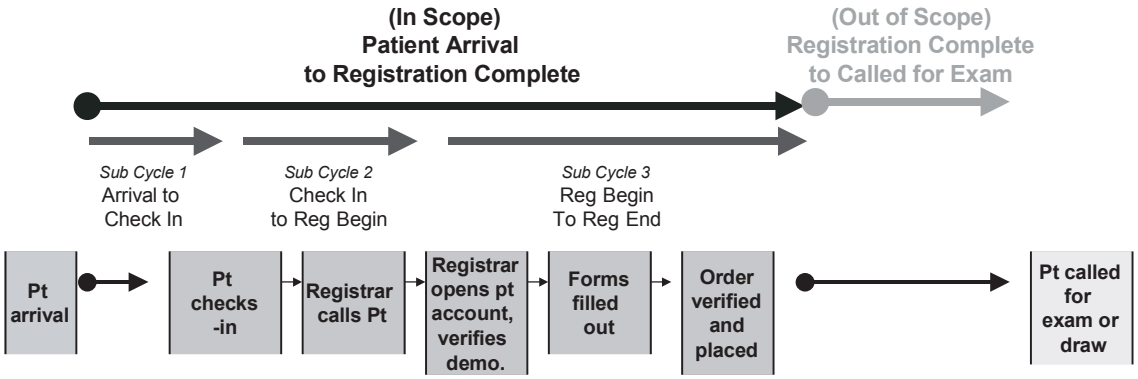
Next, detailed data were collected on each registration. To understand why one registration took six minutes and another took two minutes, registrars filled out a short form for each patient. The form listed 30 factors that might make a registration time-consuming. The registrar circled all factors that applied and then recorded how long the registration actually took.

When the project team analyzed the data with statistics, several key factors were revealed to cause long registrations. These were: the patient was talkative and had questions; demographic/insurance data were updated; the order was missing; and the patient could not quickly locate his or her insurance card.

The project team brainstormed solutions for each of these. To assist when the patient was talkative or had questions, registrars received scripting and training on how to politely close the conversation. To expedite demographic/insurance updates on the host computer, the project team recommended implementing kiosks to allow patients to update personal information themselves. To reduce the number of missing orders, an order tracking system was developed internally. Finally, to remind patients to have their insurance cards handy, signage was improved.

Thanks to the rigor of Six Sigma, these changes helped bring our wait time in line with patient expectations. "Six Sigma is becoming the way we do things at Providence," says Gail Mitchell, regional director, access services. "The invest-

Process flow with Providence project



Source: Providence Health System

ment has been invaluable."

Providence's second major investment was creating a unique department to improve processes related specifically to patient access. At Providence, we take being an integrated delivery system very seriously. We want our patients' experiences to be *seamless* as they receive care at different Providence entities. Aptly named, the Seamless Access department has worked with our seven Oregon hospitals, our 40-plus physician clinics, our home services division, and our 250,000-member health plan to, very simply, *know* our patients.

With each entity operating different core systems, the road to seamless access was paved with many challenges. We couldn't share data. We repeatedly asked our patients for their address, phone number, and insurance information. Our patients wondered why our different sites didn't "talk" to one another.

The biggest milestone for Seamless Access will be when Providence installs a new enterprise master patient index system. While this is several years away, the Seamless Access, Information Services, and Access Services departments, among others, are busy discussing requirements. Providence hopes to connect its hospitals, clinics, health plan, and home services one day.

In the meantime, Seamless Access has focused on process improvement within the billing offices and within Access Services.

A centralized call center was established for billing questions. Call center representatives were trained on both the hospital and the clinic billing systems. Representatives could help patients with account questions, demographic or insurance updates on both accounts with one phone call. We made ourselves more efficient and saved our patients a phone call at the same time.

To make paying hospital and clinic bills more seamless for our patients, a web site that accepts payments for either account was developed. Patients click on a picture of their bill to ensure that payment is directed to the right billing system. Patients enjoy the convenience of paying via the web; the billing office likes having this process automated.

The on-line payment application has improved processes for Access Services as well. Registrars can process credit card payments of co-pays faster than ever before. Registrars toggle to the payment web site and enter the patient's account number. The patient's name and address auto-fill into the on-line payment screen. Once the credit card number is typed in, the transaction is sent and a receipt prints. Registrars no longer walk to a shared credit card terminal and handwrite receipts. ■

Emergency preparedness initiative launched in GA

Resources to be listed on-line

An emergency preparedness platform that will allow hospitals throughout the state to communicate in the event of a disaster or public emergency is being launched by the Georgia Hospital Association (GHA) in collaboration with the Georgia Department of Public Health (DPH).

The purchase of the platform — funded by a grant from the DPH — makes Georgia the first state in the country to have standardized emergency software for all of its more than 150 acute care hospitals, says **Kevin Bloye,** vice president of public relations for GHA.

"The platform is going to allow our acute care facilities to list their resources that are available during a disaster," Bloye adds. "Every member can go on, see every other hospital in the state, and see where they can transfer patients and where they can't."

The system, a product of Madison, NJ-based LiveProcess, features an on-line bulletin board where people can communicate in real-time, as well as a module that provides drill scenarios, he says. "It opens up the avenue for hospitals to communicate not only among each other but with the DPH and other state agencies."

Emergency preparedness has been a top priority issue in Georgia for the past three years, says Bloye.

"We've been fortunate enough to avoid the real disastrous hurricanes, but we did have a big scare about four years ago in which most of Savannah was evacuated," he adds. "It was an eye-opener for us in that [agencies and hospitals] had trouble communicating with each other and determining what resources were available. We were not as organized as we would have liked."

At that point, the GHA began working on an emergency preparedness plan, Bloye says. "The hurricanes over the last couple of years, and this last summer, underscored the fact that we needed to take a leadership role [to ensure that] hospitals can respond appropriately. It could happen here, and we want to be ready."

Updates, HIM integration cited

At Martin Memorial Hospital in Stuart, FL, which was hit by hurricanes Francis and Jeanne in 2004 and by Hurricane Wilma in October 2005, **Carol Plato,** CPAM, CMPA, director of corporate business services, has been seeking information about web-based systems for monitoring bed availability and transferring patients to other facilities during such emergencies.

What she found is that "the technology is there and probably available to everyone, but it seems like there would be staffing needs — someone to sit there and update it," Plato says. "What would have to happen, the way we envision it, is that someone [at each hospital] would have to be very religious about putting the numbers in every day at a certain time."

Her concern, she adds, is that if someone has to stop what he or she is doing and input the information, it won't happen. One hospital manager on a listserv Plato was visiting "said nobody was using [the system in that state]. If you have to do it manually, some people won't do it, and if it's not done consistently, what's the point?"

Plato's conclusion, she notes, is "if [the system] is not integrated with the hospital's health information management [HIM] system and automatically updates, it's not worth it."

Assuming that can be worked out — in the

same way that hospitals automatically communicate health care statistics each night, Plato says that the "issue is, 'Who is going to be the gatekeeper?'"

A concern would be if one hospital company — say, HCA Inc., which has a large presence in the South — oversaw the system and only those hospitals participated, she says. "You'd need to get away from [limiting it to categories such as] non-profits, privates or religious [facilities]."

The state hospital association would be a logical choice to oversee the process, she says, "but not every hospital belongs."

While Bloye agrees that the emergency preparedness software is only as good as its users, he points out that a strong staff support system is already in place for Georgia's new platform.

"One person in all of our member hospitals is assigned to be an emergency preparedness coordinator," he says. "It is their job to update the LiveProcess site."

While the coordinators are employees of the individual hospitals and — except at the larger facilities — have other job responsibilities, Bloye says, they are "a very tight group and take this job pretty seriously."

These employees previously were charged with manning an earlier emergency web site, he adds. "During Hurricane Katrina, they were asked to get on that site and update their bed inventory and other resources. If they are as dedicated to [the new LiveProcess system] as they have been to other mechanisms, we feel it will be a huge success."

Platform aids financial recovery

The focus of the LiveProcess platform is not only to prepare for emergencies, but to facilitate financial recovery, says company CEO **Nathaniel Weiss.** "We help hospitals through all of the phases, prior and post-disaster."

In addition to assisting with patient transfer and tracking, LiveProcess assists with reimbursement from the Federal Emergency Management Agency (FEMA) and other government agencies, he says. "All is thrown into disarray in an emergency. The way we help is that we provide a framework for [the necessary] communication and a way to document every aspect of that."

When Hurricane Andrew hit Florida a number of years ago, Weiss recalls, many affected facilities were told by FEMA to go ahead and spend money on certain resources — extra oxygen, stretchers, etc. — and they would be reimbursed. However, when the facilities sought reimbursement, he says, they were told they needed documentation, and that the information had to be provided by a certain date.

Many had not done the necessary tracking, and so were unable to meet those requirements, Weiss adds. "You need a clear document track to be able to do that."

The platform also helps with the regional interoperability and dependency that often is part of a disaster response, he notes. When, for example, a chemical spill occurred in southeast Georgia, overwhelming the resources of a small nearby hospital, Weiss says, the facility called on a regional medical center located in Savannah.

"The larger hospital tried to coordinate the response, to get the vendors they needed, but the real difficulty was they didn't know how much money they could spend on behalf of the smaller facility," he adds. "This also implicates the hospital's insurance. There are policies that reach a certain level and then defer to other reimbursers."

With the LiveProcess standardized format, officials at the larger hospital would be able to, for example, pull up a screen and immediately see who the financial officer is at the smaller facility and communicate directly on such issues, Weiss says. "This is a tool to facilitate communication, planning, and response, and it's very transparent. While you're doing your job, everything is being archived and documented."

With insurers "carving out different areas of impact or threat and creating terrorism-specific riders," this kind of documentation becomes increasingly important, he points out. "Many insurers are enhancing policies to be much more specific about what is covered in the event of a hurricane. It's also fascinating that many are starting to go into a hospital and require that they be able to see the facility's emergency manage-

COMING IN FUTURE MONTHS

- Providence implements check-in kiosks
- A different kind of customer service
- An update on regulatory concerns
- Staff training techniques explored

ment plan — how it's put together."

Being able to ensure consistency across a state's hospitals is also important, Weiss adds. "The way most hospitals do emergency planning, there are 200 hospitals and 200 different plans and formats. There is a lack of quality and standardization. This offers a way to dramatically improve that." ■

NEWS BRIEFS

Guide describes 'surge hospitals'

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued a guide describing how community, state, and federal health care planners can establish temporary facilities, called "surge hospitals," to supplement existing hospitals in an emergency.

The guide examines the various types of surge hospitals, and how to plan for, establish, and operate them. It also explains how surge hospitals were established during the recent hurricanes in the Gulf Coast.

"Hurricanes Katrina and Rita have shown us that having plans to 'surge in place,' meaning expanding a functional facility to treat a large number of patients after a mass casualty incident, is not always sufficient in disasters because the health care organization itself may be too damaged to operate," JCAHO officials note. ■

Pay-for-performance analyzed in report

Pay-for-performance has the potential to increase the use and quality of "effective care," but is not likely to help reduce the rising costs of health care, according to a recent study sponsored by the Commonwealth Fund.

Effective care is therapy that is viewed as medically necessary based on clinical outcome evidence — for example, the use of beta-blockers after a heart attack.

According to author John E. Wennberg, of the Dartmouth Medical School, effective care is underused and influences only a relatively small proportion of the health care dollar. As a result, he said, it won't influence health care costs to the same extent as "preference-sensitive care," which involves significant tradeoffs based on a patient's values, and "supply-sensitive care," in which the supply of resources dictates the frequency of their use.

Wennberg said preference-sensitive care is misused and supply-sensitive care is overused, but he predicted pay-for-performance strategies, along with efforts to reward efficient providers and pay for infrastructure for the management of chronic illness, could promote reform. ■

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

Survey: Americans worried about health info privacy

Most have favorable view of health information technology

A survey from the California Health Care Foundation finds that despite new federal protection, 67% of Americans still are concerned about the privacy of their personal health information and are largely unaware of their rights. Survey results also indicate many Americans may be putting their health at risk by doing things such as avoiding their regular physician or forgoing needed medical tests. And the survey found that a majority of consumers are concerned that employers will use their medical information to limit job opportunities.

Despite their concerns, consumers generally have a favorable view of health information technology and are willing to share their personal health data when those offer a benefit, such as improving coordination or safety of care.

"These findings will help inform and guide efforts to build a nationwide health information network," said foundation program officer **Sam Karp** at a news conference announcing the survey results. "Americans' privacy concerns pose potential barriers to realizing the significant benefits of health IT to improve health care quality, reduce medical errors, and lower health care costs. Without better education about their rights, strong privacy safeguards, and vigorous enforcement, the public's support for health IT may be in jeopardy."

The 2005 survey follows a groundbreaking 1999 study on medical privacy. Since the initial survey, national privacy protections have been implemented under HIPAA. The latest survey found that Americans continue to show high levels of concern about personal health information privacy. Ethnic and racial minorities (73%) and chronically ill populations (67%) show the most concern. The survey also found that 25% of consumers are aware of recent privacy breaches reported in the media. And of those who are aware of those incidents, 42% say the reports increased their concern about their own medical privacy.

While a majority of consumers (67%) have some level of awareness of federal laws that protect the privacy and confidentiality of personal health information, awareness of privacy rights varies with education and race, with ethnic and racial minorities the least likely to acknowledge or recall receiving notification of their privacy rights (60%).

More worried about what employers will do

The survey found that concerns about employer use of medical claims information has increased dramatically from 36% in 1999 to 51% in 2005. Ethnic and racial minorities (61%), the chronically ill (55%), older workers (51%), and people with less education (53%) were significantly more concerned that an employer would use medical information to limit their job opportunities.

"Although employers work to ensure that their health plans or third-party administrators always keep all medical claims data private and confidential, in line with federal and state laws as well as professional ethics, this survey suggests that we need to work harder and communicate more effectively to reassure employees and their dependents," said **Helen Darling**, president of the National Business Group on Health. "We need to demonstrate through frequent communications that trustworthy systems with many safeguards are in place to ensure that their records are safe and can never be used in ways they haven't authorized."

The survey found that one in eight consumers engage in behaviors intended to protect their

privacy, including asking their physician not to record a health problem, going to another physician to avoid telling their regular physician about a health condition, and avoiding some medical tests. The chronically ill are more likely to risk their health over privacy concerns. Privacy protective behaviors also have increased for people with diseases such as cancer, diabetes, and depression.

"People should not have to sacrifice their health in order to shield themselves from job discrimination and loss of health benefits," Health Privacy Project director **Janlori Goldman** said at the news conference. "The large rise in people fearful that their medical information will be used against them on the job makes it imperative to expand the scope of health privacy law to cover employers."

Despite increased concerns about health care privacy, the survey found that most Americans (59%) are willing to share their personal health information when it is beneficial to their care or could result in better coordination of medical treatment.

The largest motivating factors for consumers to share their medical data are better treatment coordination (60%), enhanced coverage benefits (59%), and access to experimental treatments (58%). Consumers are most willing to share medical information with their regular physician (98%) or other physicians involved in their care (92%), but less willing to share with drug companies (27%) or government agencies (20%).

Download an executive summary and detailed survey findings from www.chcf.org. ■

AHA wants contingency period for attachment rule

AHA warns standard should have strict limits

The American Hospital Association (AHA) has told the Centers for Medicare & Medicaid Services (CMS) that hospitals should have a contingency period of at least three years after a final rule on standards for electronic health care claims attachments is issued to allow hospitals adequate time to prepare budgets, train staff, and conduct testing with their trading partners.

In comments on a proposed rule for the standards, the AHA said it welcomed many of the proposal's recommendations, but emphasized the importance of having an attachment standard that also imposes specific limitations on its use. "Without strict limits," the AHA said, "we will see inappropriate use of the attachment standard. The practice of requesting an attachment should be rare and never become a routine item that would accompany all claims for a specific type of service. Health plans and others that require routine reporting of a particular piece of data have opportunities to present their requests to the appropriate data content committees. Misuse of the attachment standard will increase not only the administrative burden and costs for providers, but more importantly, the potential for privacy violations."

The AHA cautioned the proposed standards introduce several elements not widely used in the current billing process, thus requiring new methods for capturing and handling clinical information at significant cost to providers. "We believe the attachment standards will yield a zero net return on investment for hospitals," the association said. "Moreover, the attachment standards will be far costlier to implement than the previous HIPAA claims standards."

One area of significant concern to providers not directly mentioned in the proposed rule involves establishment of a formal communication process between providers and health plans, the AHA said. "Today, many claims are delayed pending additional information from the provider," the AHA said. "However, hospitals are often unaware that the health plan has submitted a request for additional information and are left wondering about the status of their claims. The health plan's request is often lost as it moves from the health plan to the clearinghouse and sometimes even to an unspecified location within the provider's operation. The communication flow is unpredictable. Clearinghouses usually do not know how to handle such requests, and consequently they are unable to direct the request to the responsible person at the provider's operation.

"We would welcome a set of comprehensive business rules that would improve how covered entities would formally communicate with one another to handle such requests on a timely basis. While the request transaction standard includes specific contact information about the contact at the health plan, there is no comparable segment for the provider to indicate the contact person within its operations. It is unfortunate that the claim standard does not have a similar segment

that would allow providers to designate contact persons within their organizations to handle specific types of attachment requests. We recommend CMS establish a technical group to explore options for creating better communications between providers and plans."

Finally, AHA recommended that CMS issue rules for ICD-10 adoption before finalizing the rule for claim attachments, since ICD-10 provides greater clinical specificity and has the ability to reduce or eliminate reliance on claim attachments. ■

Court rejects privacy suit related to HIPAA

Decision reinforces status quo

A federal appeals court has rejected a challenge by patient advocacy groups to a rule promulgated under HIPAA that eased a prior regulation to permit health care entities to use and disclose individually identifiable health information for routine uses without obtaining prior consent. The advocacy groups had argued the more permissive rule violated their substantive due process rights, the First Amendment, the Administrative Procedure Act, and HIPAA itself. But the Third Circuit Court of Appeals rejected these arguments, saying that HIPAA may be implemented in a manner that places reasonable limits on the privacy protections available under that law. The court expressly said the objective of protecting patients' privacy must be balanced against the statute's other legitimate goals.

In an analysis for Sidley Austin LLP, attorney **Alan Raul** said that while the advocacy groups argued that elimination of the consent requirement for routine uses violated their privacy rights in violation of the Fifth Amendment's due process clause, the court found that the alleged privacy violations were attributable to private entities and not to the federal government. Raul said the court reasoned that the groups were not challenging the protection of health information by the government itself, but rather were concerned about use and disclosure of their health information by third parties such as pharmacies and private health care entities.

The court also was not persuaded by evidence that some covered entities had relied on the amended rule to change their privacy policies, Raul said. In the court's view, "the fact that a private party changed its behavior in response to a law does not give the law the coercive quality upon which the state action inquiry depends unless the law itself suddenly authorized something that was previously prohibited."

Since Citizens for Health and the other plaintiffs were not able to demonstrate that pre-HIPAA law prohibited covered entities from using or disclosing information for routine uses without consent, the court concluded that the amended rule neither authorized previously prohibited conduct nor enhanced the ability of these entities to engage in the challenged conduct.

The court's reasoning in rejecting a First Amendment argument was similar in that it found that any potential chilling effect on communications between patients and health care practitioners could be attributed not to any government action but rather to decisions by private entities regarding the manner in which they would use or disclose health information.

The advocacy groups also contended the amended rule violated HIPAA itself because the statute permits the Department of Health and Human Services to enact only those regulations that enhance privacy and not any regulations that detract from it. And they argued that the amended rule conflicted with Congress' intent in that it disturbed individuals' reasonable expectations of privacy in their medical information.

But the court rejected the contention that medical policy is the controlling policy underlying HIPAA, saying such a one-dimensional view ignores HIPAA's other goals of administrative simplification and improving health system efficiency and effectiveness. According to the court, the goal of protecting privacy must be balanced against these other equally important objectives.

Raul tells *HIPAA Regulatory Alert* he does not expect the case will be pursued any further, especially since HIPAA does not permit private actions, but limits compliance to criminal cases by the government against violators.

"This was a complex legal challenge to a complicated federal regulation and a decision that upholds the government's authority to issue such regulations," he says.

The decision makes no change to the status quo for the average patient, Raul says, and should not result in transformation of any practices that affect individuals. "Had the decision gone the other way," he says, "there would have been a major

change to the status quo."

Download the decision at www.ca3.uscourts.gov/opinarch/042550p.pdf. ■

CMS: PHI can be disclosed for payment purposes

'Payment' includes determining eligibility

The Centers for Medicare & Medicaid Services (CMS) says a state Medicaid agency and Medicare Advantage plan may share protected health information to identify dually eligible enrollees. In a question and answer session posted at the Department of Health and Human Services web site, CMS said the HIPAA privacy rule permits a covered entity to disclose protected health information for its own payment purposes and for the payment purposes of another covered entity that receives the information.

The privacy rule defines payment to include activities to determine eligibility or enrollee coverage. Thus, the note says, a Medicaid state agency and Medicare Advantage plan may disclose to each other protected health information about their enrollees to identify those enrollees who are dually eligible under both plans.

In general, an electronic inquiry and response from one health plan to another to obtain information about an enrollee's eligibility to receive health care must be done using the HIPAA standard transaction for eligibility. While the disclosure between the state Medicaid agency and the Medicare Advantage plan are conducted using the standard, the privacy rule's minimum necessary requirements don't apply to disclosures of the data elements required or situationally required by the standard transaction. In contrast, where disclosures are made outside of a standard transaction, both the Medicare Advantage plan in its request for protected health information, as well as the state Medicaid agency in its response, must make reasonable efforts to limit the necessary protected health information for the purpose of identifying dually eligible enrollees.

Because the Medicare Advantage plan must limit its request to the minimum necessary protected health information to identify dually eligible enrollees, the state Medicaid agency may rely, if reasonable, on that request for protected health information as satisfying the minimum necessary requirement for these purposes, CMS said. ■

EPIC warns about DTC marketing databases

Concern over targeting vulnerable groups

The Electronic Privacy Information Center (EPIC) West Coast Office has told the U.S. Food and Drug Administration (FDA) it is concerned about an issue in direct-to-consumer (DTC) medical marketing that it believes has received inadequate attention — use of databases of personal information to target individuals with medical ailments through direct mail or other forms of direct marketing.

"We are concerned that heightened attention to traditional mass-circulation print and broadcast advertising will result in marketers increasing information collection efforts for targeted solicitations," EPIC senior counsel **Chris Hoofnagle** said in comments to FDA.

EPIC said there are several reasons why a shift to more direct marketing presents risks to privacy and consumer welfare. First, it said, data brokers (companies that amass personal information and sell it to marketers and others) can enable targeting of DTC advertising to vulnerable populations. That risk is exacerbated by the fact that, unlike mass-circulation print and broadcast advertising, targeted solicitations are harder for public health authorities to monitor.

Second, according to EPIC, medical information often is gathered in a deceptive fashion, such as consumers being presented with product warranty or registration cards that solicit medical information, with the false implication that completing the card is necessary to have protection for a product. And finally, EPIC said medical information is being gathered outside the protections of HIPAA's privacy regulation since individuals who give their medical ailment information to marketers have no ability to opt out of the data collection, to access their data or correct it, or to order that the data be deleted.

EPIC urged the FDA to consider risks posed by an increase in use of personal information to target DTC advertising. It said new database technology makes it simple for marketers to target vulnerable groups. ■