Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

MAY 2006
VOL. 25, NO. 5 • (pages 49-60)

'Everybody learns, everybody teaches' in collaborative on upfront collections

NAHAM initiative result of calls for best practice data

A collaborative on upfront collections sponsored by the National Association for Healthcare Access Management (NAHAM) turned out to be "a good experiment" that allowed participants to learn from their counterparts in other hospitals while also working alone in their own organizations, says **Karen McKinley**, RN, MBA, CHAM, vice president of the division of clinical effectiveness at Geisinger Health System in Hershey, PA.

The average increase in upfront collections among participating hospitals was about 30% during the 15-month time frame for the collaborative, which began in October 2003 and ended in December 2004.

The initiative came out of ongoing calls for best practice and benchmarking information from NAHAM members, adds **Pete Kraus,** CHAM, business analyst, patient accounts services at Emory University Hospital in Atlanta. McKinley, Kraus, and **Nancy Farrington**, of Main Line Health System in Berwyn, PA, served as faculty for the collaborative.

The project — suggested by McKinley in the wake of a large clinical collaborative in which Geisinger participated — provided that information without the more costly investment of research and resources required by the benchmarking process, Kraus adds.

While "benchmarking" has been defined as "the process of determining who sets the standard, and what that standard is," a collaborative can be described as a "joint effort among multiple organizations that share resources and information," according to materials prepared by organizers of the NAHAM collaborative.

Putting that even more succinctly, McKinley adds, "Everybody learns, everybody teaches. It's a methodology that's easy for NAHAM, because it's always been about sharing." **(See collaborative model, p. 51.)**

To facilitate the project, a web site was created where the participat-

ing hospitals could chart their progress, Kraus explains. Each facility set its own goals, and three measures were taken: total upfront dollars collected, self-pay charges collected upfront, and emergency department (ED) dollars collected upfront.

Participants recorded on the graphs the percentage of the goal attained during each reporting period.

"Once a month, [participants would] call and get together, and update the graphs on the web site," Kraus says. "It was a collaborative on at least two levels — in the facility itself and in the individual department."

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

Subscriber Information

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

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

Editorial Questions

Call **Jill Robbins** at (404) 262-5557

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Lila Margaret Moore**, (520) 299-8730.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@thomson.com).

IHI model used

As part of her work in clinical effectiveness at Geisinger, notes McKinley, a former access director and a longtime NAHAM member, she has been involved with the Institute for Healthcare Improvement (IHI) for about eight years.

"What we talked about doing was trying to find a way to do improvement work, but also getting some measures that could be used to benchmark," she says. "We used the IHI collaborative model, which is very public."

The role of the collaborative faculty began with educating participants about improvement work by giving them the tools to help establish an aim or goal for what they wanted to achieve, McKinley explains. "Once they knew the target or goal, they could go about doing the work to improve.

"It starts by building a team of people to talk about it," she says. "You do brainstorming around areas to improve, then focus in one or more areas, make small changes, and measure them."

One of the key steps in the process, McKinley says, is doing what the IHI model terms "tests of change."

Once a team has set its aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting, according to the IHI.

The Plan-Do-Study-Act (PDSA) cycle, she says, is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned.

The reasons to test changes, according to the IHI web site, are:

- to increase your belief that the change will result in improvement.
- to decide which of several proposed changes will lead to the desired improvement.
- to evaluate how much improvement can be expected from the change.
- to decide whether the proposed change will work in the actual environment of interest.
- to decide which combinations of changes will have the desired effects on the important measures of quality.
- to evaluate costs, social impact, and side effects from a proposed change.
- to minimize resistance upon implementation.

'Just ask'

After the first eight weeks of the collaborative, Mt. Graham Medical Center, a 59-bed hospital in Safford, AZ, went from collecting $1,700 a month to collecting $7,800, says **Candi Garcia**, supervisor of admissions. **(See charts, p. 52.)**

"We found in this collaborative that the most important thing was to just ask for the money," she adds. "A lot of our employees weren't asking. Once we pushed it, and they got it as a mindset, we increased 78% over eight weeks and probably stayed at about that. Once we got in the groove, it just worked for us."

One of the first conclusions reached by the group as a whole was that, no matter what, a hospital had to have its administration behind the collections effort, Garcia notes. "That's where it has to start, and we did have that 100%.

"The first thing we did was go to our chief financial officer," she recalls. "We told him about the collaborative, and got strong support. Then we set up a meeting with our patient accounting [staff] and our whole administration."

To make sure access staff were fully prepared for the collections initiative, Garcia says, arrangements were made for a senior admitter to work one on one with each employee.

"He took each admitter and gave them three to four hours," she says. "He started at the beginning and went through the entire process and all the insurance codes. He made sure everybody was asking the patient the questions the right way."

In addition, Garcia says, every Mt. Graham admitter spent about two hours with the patient accounting staff, stressing the importance of getting every piece of information correct and explaining what happens if there is a mistake in the patient's address, for example, or if the insurance policy number is wrong.

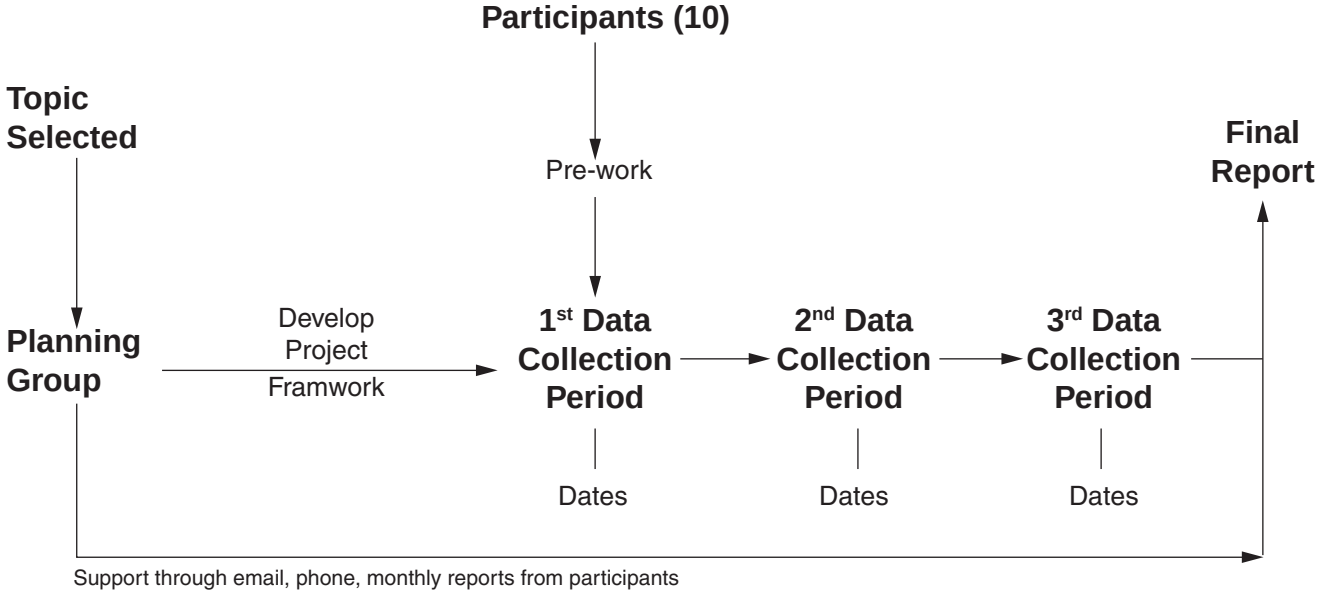
Because Mt. Graham is a small hospital in a rural community, it didn't have many self-pay patients, compared to the other participating facilities, she adds. "Even though only 5% of our community is self-pay patients, we wanted to come up with a way to help them also, so [it was decided] that if they could pay the bill upfront, they would get a 30% discount."

That discount is not just for ED charges, she notes, but includes all hospital departments.

As part of the effort to obtain copays and deductibles at the time of service, Garcia says, her staff went over the hospital's most common insurances and made lists of the required payments. "We made phone calls and found out what [the copay/deductible] was in the emergency department, and what it was for labs and X-rays. We made cheat sheets and gave them to every department, so they would know what to collect."

The process was simpler for Mt. Graham than

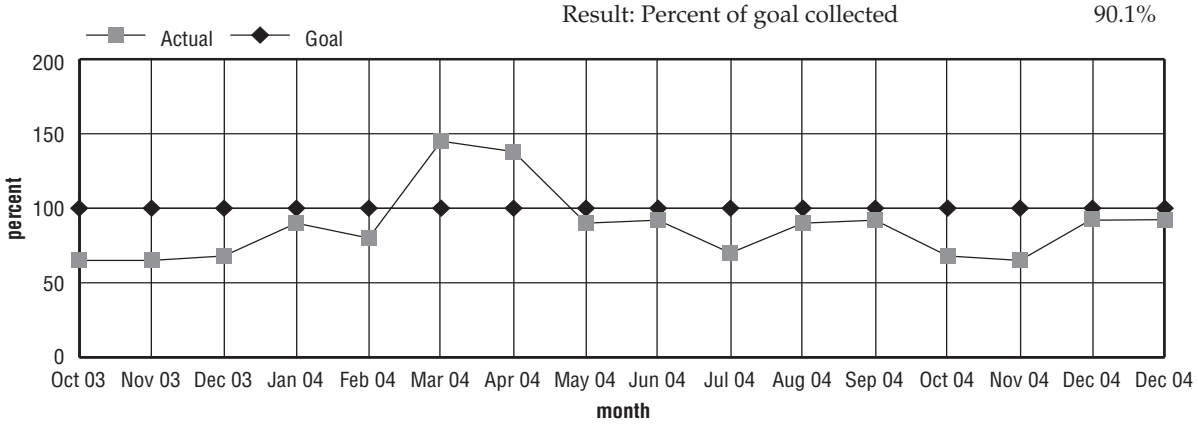
Collaborative Model



Source: Mt. Graham Regional Medical Center

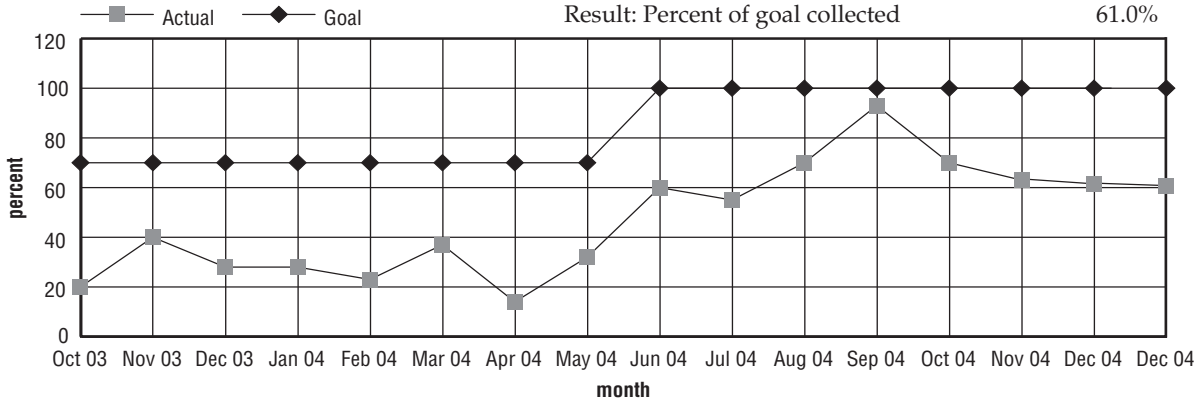
Percent of Total Upfront Dollars Collected

Total upfront dollars collected current period (include inpatient, outpatient, ED)	11,579
Monthly goal:	12,850
Monthly goal %:	100%
Result: Percent of goal collected	90.1%



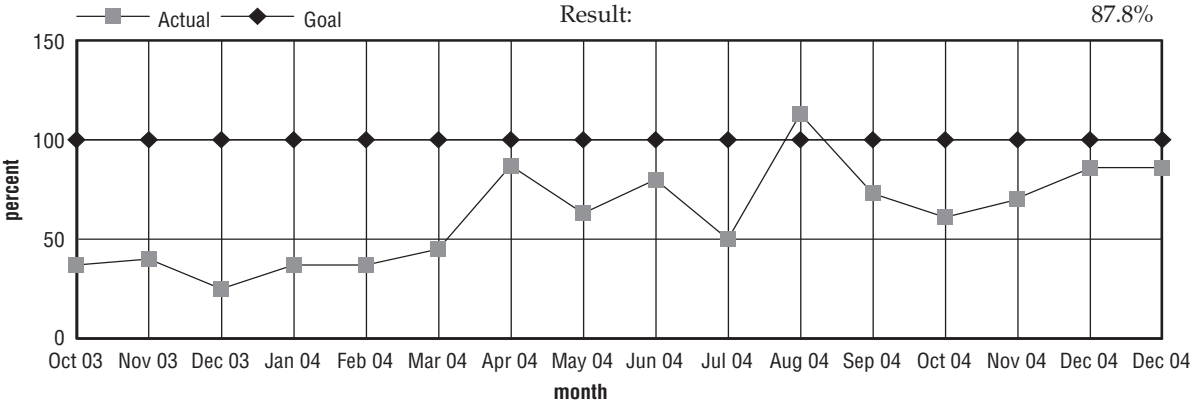
Percent Self-Pay Charges Collected Upfront

Total self-pay dollars collected upfront (include IP and OP only)	8,725
Total self-pay charges for month:	14,263
Percent of self-pay charges collected upfront:	61.2%
Monthly goal:	100%
Result: Percent of goal collected	61.0%



Percent of ED Dollar Goal Collected Upfront

Total ED dollars collected current period:	2,854
Monthly $ goal for ED:	3,250
Monthly goal %:	100%
Result:	87.8%



Source: Mt. Graham Regional Medical Center

it would be for most other hospitals, she notes, because there are a few main employers in the small town of Safford that account for most of the patients' insurances.

That was one of a number of ideas discussed among participants in the monthly conference calls, Garcia says. **(See related story, this page.)**

During these monthly sessions, which lasted between 45 minutes and an hour, she adds, "all of us would tap into the NAHAM web site and get into our charts. We would look and see how each [facility] had improved or was down. If someone's [collections were] down, we would talk about it with them, and about how to get them up."

Another brainstorm that came out of the collaborative phone conferences was conducting morning "huddles," she says. "The idea was to have one team leader on each shift talk with [other registrars] about the goals for the day, how much they would try to collect."

That didn't work for Mt. Graham, Garcia says, because there are only about six or seven admitters on duty in the hospital on any given day. They aren't in a position to "huddle" because they are spread among the ED, the main admitting area, and radiology, she notes.

Goals, incentives tailored to each facility

Some of the organizations, including Mt. Graham, provided rewards and recognition for registrars who met certain collection goals, Garcia notes. These included "dress-down" days, gift certificates, parties, and lunch, as well as celebrating high achievers at staff meetings and in hospital newsletters, she says.

One of the things Garcia did — and shared with other members of the collaborative — was to take about half her admitting employees to a seminar in Phoenix called "Get Your Ask in Gear," she adds. "Once I mentioned that at the [NAHAM] conference, I had everybody wanting to know what it was."

Other hospitals, Garcia says, got good results from putting a credit card machine and/or a cash collection box in the ED to make it easier for patients to make a payment.

While the key measures of the collaborative were selected by a planning group, she points out, participants refined those measures and set specific goals appropriate for their individual hospitals. That could mean focusing on, or excluding, a particular department or category of patient.

For example, Mt. Graham measured total dollars collected upfront, self-pay dollars collected upfront, and ED dollars collected upfront, she says, while Girard Medical Center and St. Joseph Hospital, both located in Philadelphia, only measured the first two components.

The two Philadelphia hospitals, each about three times the size of Mt. Graham and in busy, urban settings, "have so many people coming in and out, so many self-pay patients, that they didn't have the time and manpower to do the third [measurement]," Garcia adds.

Despite such differences among hospitals, the group's experience was that the collaborative approach can work for all, she notes. "You approach it differently, and make goals that [are realistic] for your facility. "Our money collected upfront is nothing compared to those hospitals, but look where we are located. It just depends on the area you are in."

Julie Johnson, CHAM, director of revenue cycle management and HIPAA privacy officer at Mt. Graham, says she has observed that chief financial officers who ask "What's in it for us?" when it comes to benchmarking clearly see the benefits of a collaborative.

"With this, each hospital saw improvement, something that happened for its own benefit," she adds. "[Participants] were mentoring each other on things that worked and those that didn't work."

As a NAHAM board member, Johnson says, she was eager to volunteer Garcia and Mt. Graham to be part of the collections collaborative — and did so again when a project on medical records and patient safety was started in 2005.

"I see it as a benefit for our facility and a growing opportunity for leadership," she says. "It's important for us to participate when there is an opportunity."

(Editor's note: Candi Garcia can be reached at candig@mtgraham.org. Pete Kraus can be reached at Pete.Kraus@emoryhealthcare.org. Julie Johnson can be reached at juliej@mtgraham.org.) ■

Any collections effort 'will bring some results'

Guide available this summer

A couple of well-known slogans give a sense of the overall lesson learned from the National Association of Healthcare Access Management

(NAHAM) collaborative on upfront collections, says **Nancy Farrington**, CHAM, master person index/clinical data repository administrator at Main Line Health System in Berwyn, PA.

"Like Nike [says], 'Just do it,'" advises Farrington, who served as part of the faculty for the project. "Or, to paraphrase Kevin Costner, 'If you ask, they will pay.'"

One of the reasons the collaborative included a mix of small, large, urban, and rural hospitals was to test the idea that success was not determined by those factors, she notes, and that is in fact what the results showed.

"Any effort will bring you some results," Farrington says. "So get organized and start doing it."

There were no characteristics that were found to preclude a facility from having success in upfront collections, she says. Philadelphia's Girard Medical Center and St. Joseph's Hospital "are inner city, high poverty level with a high incidence of substance abuse and they had success."

So did Mt. Graham Medical Center, a 59-bed facility in rural Safford, AZ, with only 5% self-pay patients, Farrington says. **(See cover story.)**

The only overriding requirement is keeping focused and committed, she adds. "We did have challenges among a couple of hospitals that got diverted by other projects. If you lose focus, you lose revenue, or you increase the costs associated with getting it."

In addition to data gleaned from the collaborative, Farrington says, NAHAM also obtained information from other members who have upfront collections programs in place.

As a result, NAHAM is preparing a guide to upfront collections that will be available this summer on a CD, she notes. "It will contain sample forms and letters that people can copy and modify for their use, as well as other materials — such as policies and procedures — that can be used as models."

The guide was to be demonstrated at the NAHAM conference, held April 29 to May 2 in Phoenix, Farrington adds, and could be ordered there or via the organization's web site (www.naham.org), with a discount for orders paid for by May 31.

Access managers and directors looking to implement an upfront collections program — or build on one already in place — might want to keep in mind the following insights gained during the collaborative and from other members' experiences, she says.

- Hospitals where there was strong administrative support, at the vice president level were much more successful than those in which all the impetus came from within the access department.
- A key factor in emergency department collections was creating a place for people to go through the discharge process and make their payments. "You can't have financial discussions upfront," Farrington notes, because of EMTALA considerations.
- Provide information to patients prior to their arrival — not just the specifics of their financial obligation, but the fact that an upfront collections procedure is in place, and the reasons why.

Some of those reasons are that "it's the patient's obligation, insurance never pays 100%, and it saves money for the hospital so it can continue to provide excellent service," she points out. "One hospital put notices in the paper that they were going to do it."

- It's important from the patient's perspective to universally apply whatever message you use. If there are centralized and decentralized registration areas, for example, "you can't ask in one place and not another," Farrington advises.

"Accept payment in every possible location and type of funding — not just cash or credit card, but by whatever means the patient has available and at every point of entry."

- Hospitals should not feel that they will alienate patients by asking for payment in competitive marketplaces, even in places where competing facilities are not collecting upfront.

"It seems that even in the places where [competitors] were not already doing it, hospitals still had success," she says. While it's important to acknowledge that patients have a choice, and to thank them for choosing your facility, Farrington adds, "those choices are not based on whether the hospital collects upfront or after the fact."

- Some organizations offer discounts for prompt payment, but not all do. NAHAM surveyed it members doing upfront collections, she says, and only 42% indicated they had such a discount.

Some of those who did offer a discount said they took that step in order to take their collections program to the next level, Farrington says. Such a move is understandable, she notes, considering how expensive it is to collect retrospectively.

- Hospitals that reported the most successful collections programs (measured by low accounts receivable [AR] days) in the NAHAM survey were those that did not hire consultants, but used

their own internal resources.

• The more effort expended to identify the patient's financial obligation, the more successful the collections program was likely to be. That means not depending solely on what the patient says the deductible is, Farrington adds, but checking the information with insurance "cheat sheets" and on-line eligibility systems.

• Hospitals with the lowest AR days did not put as much emphasis on routine and recurring outpatients, she says, but gave greater attention "where they will get more bang for the buck."

Duplicate medical records next focus

Later in 2006, with the exact date yet to be determined, Farrington says, NAHAM will begin a collaborative on patient safety and duplicate medical records.

"With the growing trend toward electronic health records, this becomes more and more of a liability and patient safety issue," she points out. "When a patient has part of his or her clinical [history] on one record and part on another, the care provider doesn't have the complete picture.

"There is also a lot of administrative expense associated with it," Farrington adds. "If you make a mistake, it goes to 30 different places, but the correction doesn't [automatically] follow. It has to be done 30 times."

(Editor's note: Nancy Farrington can be reached at FarringtonN@MLHS.org.) ■

Hospital uses bright blue to nurture bottom line

Unscheduled inpatients targeted

A procedure for obtaining copays and deductibles from unscheduled inpatients during their hospital stay is the latest in a series of successful collections initiatives at Hillcrest Medical Center in Tulsa, OK, says **Julie Willis,** patient access manager.

In line with the growing industry-wide focus on nurturing the bottom line, the hospital looks for "every possible way" to bolster collections, Willis notes. "You have to be creative in the way you do it."

While registrars have been asking scheduled inpatients and outpatients to fulfill their financial obligations during the preregistration process since at least 2003, Willis says, the process for collecting from unscheduled patients began in March 2004.

After financial counselors verify the insurance and determine the copay and deductible for an unscheduled patient, she explains, they fill out a sheet with this message: "Dear Patient: Upon dismissal from the hospital, please stop by registration and pay your deductible or copay. The amount of ____ is due now. We accept cash, check or credit card." It instructs patients to direct questions to the two financial counselors who handle the process.

The message, printed on bright blue paper, is delivered to the patient's room by a registration representative, Willis says. "We have found that colored paper works well."

At the same time, she adds, the registration rep gives a notice — this one printed on hot pink paper — to the nursing staff to put on the patient's chart.

The information on the patients' financial responsibility is provided to the nursing administrator, Willis says, in the hope that he will remind nurses to bring patients by the registration desk as they are being discharged.

In some cases, however, all the registration reps have to do is ask, she points out. "It's amazing how [some patients] will just come down and pay $1,000 or $1,500."

Other times, Willis adds, the patient's family comes by later and pays the bills. If the person says he or she doesn't have a credit card or a checkbook, she notes, the registrar leaves a self-addressed envelope and asks that the payment be mailed.

The first year the process was put in place, she says, it brought in an additional $76,000, and in 2005 an extra $109,000.

"In the past, we wouldn't have gotten any money from any of them [at the time of service]. By collecting this, we've reduced the number of bills that need to go out for copays."

Willis says she has observed that the way the patient is approached seems to make a difference in whether a payment is made or not. "When [the registrar] is a cheerful, high-energy person, [he or she] seems to collect more than a timid person."

About 34% of patients who are handed the notices end up paying the copay or deductible before they leave the hospital, she says. "We feel there are more we could collect from. The next step is to have someone assigned to follow up

again, probably with a telephone call or an additional visit to the room."

In the case of scheduled patients, Willis notes, staff also call and verify benefits and get copay information, and fill out a colored sheet to let registrars know how much to collect when the patients arrive. Registrars inform patients of the copay or deductible amount when they call to gather demographic information, she adds.

"That works very well," Willis says. "Sixty-eight percent of our total collections are from scheduled patients."

Total collections in 2003, the year staff began asking for upfront payment, amounted to $852,000, she says, compared to $679,000 in 2002. By 2004, total collections — for inpatients, outpatients, and the emergency department — equaled $1.3 million, Willis says.

A self-pay coordinator works all the self-pay accounts, both inpatient and outpatient, she notes. "Basically, with non-urgent procedures, we give the patient an estimated price. The person has to be able to pay a minimum deposit and sign a promissory note."

Self-pay patients receive a 30% discount, Willis adds, if they pay half the bill upfront and the balance in 30 days. "A lot of them take advantage of that."

If the person is unable to pay the minimum deposit, she says, there is a medical review to determine if the procedure can be postponed until the financial obligation can be met, or if an exception will be made.

[Editor's note: Julie Willis can be reached at (918) 579-5035.] ■

Physicians get access to outpatient schedule

Appointments made on-line

Kettering Medical Center Network (KMCN), of Dayton, OH, is expanding its customers' opportunities to do business on-line by offering physicians the ability to access hospital software and schedule outpatient appointments.

With a successful pilot project already under way, says **Jana Mixon,** patient access manager for Kettering Memorial and Sycamore hospitals, "we're getting ready to roll out specific abilities for physicians who have privileges at our facility to have their office staff go on-line and directly book an outpatient test."

"This allows the physician to communicate with the patient right there in the office, give the preparation information for the test, and have the patient walk out with [an appointment slip] in hand," Mixon adds. "The physicians do have to follow up with a written order, which they fax to us."

The pilot program, in the office of "one of our busy cardiologists," is going well, she says, and tests are being scheduled without telephone calls. "The physician and his staff can see the schedule and where the openings are. It's a real patient and physician satisfier."

In the past, Mixon explains, the office staff would call in or fax the hospital a physician's order and access staff would "play phone tag" with the patient to schedule the appointment. After connecting with the patient, she adds, schedulers then would transfer the person to be preregistered or preregistration staff would place a separate call. "So you can see [the new process] eliminates several steps."

The pilot project started in the summer of 2005, Mixon says, and the goal is to have at least 30 physician practices up on the scheduling software by the end of 2006.

"We're going into internal medicine, the obstetrics practices — there's not going to be a limit," she adds. "If it will benefit you, we will develop it for you."

The process will be specifically designed for each practice, Mixon says, and there will be limited access based on specialty and needs. "A cardiologist wouldn't have access to obstetrical ultrasound [appointments]."

There is no cost to the physicians, she notes. "It's mainly giving them access to our system. They log on to a secure web site and outpatient scheduling software that is maintained on our system."

The biggest challenge, Mixon says, has been making sure to provide the physician's office with the necessary educational support, "things like letting them know a particular test shouldn't be scheduled at a specific time, different exceptions that need to be made."

To provide that help, she says, the hospital has gotten approval for a full-time position in the central scheduling department and is looking for the right person to fill it. "This [new employee] will be a liaison between the physician practice and us, providing training and support and

answering questions."

There is no question that the investment is worthwhile, Mixon adds. "To have the patient walk out of the physician's office with [appointment] information in hand will impact us in a positive way financially, and with customer service and patient satisfaction.

"Any time you can make an investment in efficiency to make it easier for patients and physicians, the payoff is more than you're putting into it," she says. "By rolling out the physician web scheduler, we're pushing [the concept] that as the patient goes home, he or she can register on-line and never even have to call us.

"What we have learned, especially with on-line registration, is that the demand and the need are there," Mixon adds. "We're responding to the public's need and want to manage their health care better by doing things more efficiently."

On-line registration expanding

KMCN realized just how eager some of its customers were to begin registering on-line in 2004, Mixon recalls, when the hospital was looking into doing on-line registration and had developed a test version of an on-line form.

People began using the search box on the KMCN web site to find the test version, fill it out, and send it in, even though the service hadn't yet been offered to the public, she says. **(See cover story in the September 2005 issue of *Hospital Access Management*.)**

Since that time, Mixon adds, "once we started getting data into the system, we've done some research to find the demographics of those using [on-line registration]. We found that the majority of the registrations coming in on-line were from expectant mothers, so we pushed that. We made sure information [on the process] is included in all the material that is given to those patients, as well as targeting physician practices that send maternity patients to us."

In addition, she says, KMCN has developed on-line registration information for physician offices that inquire about the process.

There still has been no deliberate marketing of on-line registration, Mixon says, and yet the volume continues to increase. "We're now averaging about 10 [on-line registrations] a day, compared to about three or four a day when we started."

[Editor's note: Jana Mixon can be reached at (937) 395-8169 or by e-mail at jana.mixon@kmcnetwork.org.] ■

Rapid growth predicted for health manager jobs

Degrees, quality expertise important

Future health services managers — including those in access management — must be prepared to deal with evolving integrated health care delivery systems, technological innovations, an increasingly complex regulatory environment, and restructuring of work.

They increasingly will work in organizations in which they must optimize the efficiency of a variety of related services.

On the plus side, employment of managers is expected to grow faster than average through 2014, as the health care industry continues to expand and diversify.

That's all according to the 2006-2007 edition of the Bureau of Labor Statistics' (BLS) Occupational Outlook Handbook.

Access directors and managers who would like to take advantage of this growth environment should be prepared with advanced degrees and expertise in quality improvement, suggests **Deedra Hartung,** MA, vice president in the executive search division of St. Louis-based Cejka Search.

"I can't stress the advanced degree enough for those who go to market and try to be competitive in vying for manager/director positions," she says. "People really want expertise these days. Health care is complex, and [employers] want candidates with strong knowledge, not those who require on-the-job training."

A 2005 hospital CEO leadership survey conducted by Cejka Search and Solucient found that 77% of the top leadership team at "best of breed" hospitals had a master's or doctorate degree, Hartung points out, compared to 56% at "median" hospitals.

"Best of breed" referred to hospitals rated in the top 100 based on a number of measurements, she notes, while "median" hospitals were those just below that level.

Hospitals looking for top executives also are mindful that "the nation's health care agenda right now is all around quality of care, clinical outcomes, and patient safety," Hartung continues. "Just as hospitals are looking for medical executives [with this expertise], they are also looking for non-clinical leaders in the quality arena."

She cited financial incentives put in place by the

Centers for Medicare and Medicaid Services to reward hospitals for quality care work, noting that facilities in the top 20% of each clinical category can expect to receive Medicare incentive payments.

"Hospitals obviously want to participate in this 'pay for performance' program that Medicare has in place," Hartung says. "That requires having people to lead those quality initiatives, and it's a huge undertaking."

As for gaining expertise in quality improvement, she says that besides coursework and an additional degree, "there are a lot of conferences devoted to [quality] right now."

Patient satisfaction is among the quality indicators that are being monitored, she points out, "which starts with the admissions director, the access director."

Issues surrounding the widespread implementation of electronic patient records will be a big part of the technology challenges facing health care managers in the next decade. The BLS handbook notes that recent regulations enacted by the federal government require that all health care providers maintain electronic patient records and that these records be secure.

As a result, health information managers — as well as access managers and directors whose oversight extends into that area — must keep up with computer and software technology and with legislative requirements, it points out. As patient information becomes more frequently used for quality management and medical research, the report continues, the focus must be on ensuring that databases are complete, accurate, and available only to authorized personnel.

Job opportunities for health services managers will be especially good in the offices of health practitioners, general medical and surgical hospitals; home health care services; and outpatient care centers, according to the BLS handbook.

Managers in all settings will be needed to improve quality and efficiency of health care while controlling costs, as insurance companies and Medicare demand higher levels of accountability, the report states. Additional demand for managers, it continues, will stem from the need to recruit workers and increase employee retention, to comply with changing regulations, and to implement new technology.

Access professionals interested in checking out career opportunities on-line can supplement the search with web sites and e-mail lists dedicated to postings in specific fields.

Management- and executive-level hospital jobs paying a minimum annual salary of $100,000 are listed at the website of Hartung's firm, www.cejkasearch.com. Up to two new jobs are added daily and the site averages about 50 jobs.

Senior and midlevel finance jobs at hospitals are listed at www.hfma.org, the web site of the Healthcare Financial Management Association. About 50 new jobs are added weekly and around 200 jobs typically are listed. Annual salaries offered range from $60,000 to $300,000.

A broad range of openings is available at www.hospitaljobsonline.com, where between 2,000 and 3,000 new jobs are posted daily. About 50,000 positions, from entry to senior level, are generally listed and pay from $60,000 to $250,000 in annual salary. ■

On-line bonus book for *HAM* subscribers

Readers of *Hospital Access Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2006 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2006 on-line bonus report, visit **www.ahcpub.com**. ■

EMTALA court decision ignores '250-yard' rule

No 'dumping' violation found

A woman who fell and was injured in the parking lot of a medical center after arriving for an appointment had no claim against the hospital under the Emergency Medical Treatment and Labor Act (EMTALA), according to a recent decision by a California federal court.

EMTALA specialist and web site publisher **Stephen A. Frew,** JD, (www.medlaw.com) points out that there is no indication that in reaching its conclusion the court considered a Centers for Medicare and Medicaid Services (CMS) regulation involving parking lots and similar locations within 250 yards of a hospital.

That regulation, Frew notes, adds such areas to the definition of what constitutes an individual having presented to a hospital for EMTALA purposes.

The court explained its decision, he adds, by noting that EMTALA is a statute aimed at prohibiting patient dumping and that once the plaintiff was taken to the medical center she received treatment and was not "dumped."

The court further held that EMTALA contains no requirement that a medical center use its own personnel to transport a patient injured on its premises to the emergency department (ED).

According to published accounts, Frew says, plaintiff Maria Addiego was taken by her daughter to the California Pacific Medical Center for an appointment. While exiting the car in the parking garage, she fell and broke her hip.

Although they were located about 30 yards from CPMC's emergency department, he continues, the parking attendant instead called the security department, which refused the plaintiff's request for immediate medical attention from the ED. Instead, Frew adds, security personnel called 911.

After the plaintiff had been lying on the ground for almost an hour, he says, an ambulance came and transported the woman to CPMC's ED.

The plaintiff sued CPMC, alleging the delay made her injuries worse and claiming premises liability and personal injury. She also filed a separate action adding the city and county of San Francisco as a defendant and alleging that CPMC violated EMTALA by refusing to transport her to the ED, instead requiring that the San Francisco fire department do so.

Frew compared the event that sparked the California lawsuit to an incident at Ravenswood Hospital in Chicago in which a hospital ED refused to assist a teenager who had been shot and lay a short distance from the ED entrance.

Chicago's fire department emergency medical service did not respond because the incident was at a hospital, interpreting the call as a transfer request, Frew notes. Chicago police, reportedly frustrated by the standoff between the hospital and EMS, deviated from departmental rules and moved the child to the hospital ED, just yards away, he says. The child, however, died from loss of blood attributed to the delay in care, Frew adds.

In response to the Chicago event, he explains, CMS added the definition to its prospective payment regulations defining the area of 250 yards around a hospital — including access areas and hospital parking areas — as constituting "presenting to the ED" for EMTALA compliance rules. The rules also require the hospital to provide a response to the patient in addition to calling 911.

While the decision in the California case is likely to influence litigation cases arising in the Northern District of California, Frew suggests, it is unlikely to influence CMS enforcement of the 250-yard requirement. ■

Hospital pricing policies to be posted on web site

Hospitals' pricing policies for the uninsured will be posted on a web site to be established by the Consejo de Latinos Unidos (Council of United Latinos), the organization has announced.

The council says it will monitor whether hospitals are complying with and informing uninsured patients about their discount and pricing policies, and will solicit financial donations from hospitals to support its program, according to a news item at *AHA News Now*, the American Hospital Association's on-line news service.

Executive director of the group K.B. Forbes acknowledged that the council has close ties to Archie Lamb, a class-action lawyer, who, along with Richard Scruggs, has sued hundreds of hospitals across the country, challenging their tax-exempt status and alleging unfair billing and collections practices.

Nearly all of the federal lawsuits have been dismissed or withdrawn and at least 37 of the state lawsuits so far have been dismissed.

More than 4,200 hospitals have pledged to fol-

low the American Hospital Association's "Principles and Guidelines on Hospital Billing and Collections Practices" (www.aha.org), which describe an approach to helping uninsured patients of limited means pay for hospital care, the news item points out. ▼

Court upholds dismissal in tax-exempt status case

The U.S. Court of Appeals for the 11th Circuit upheld in March the dismissal of a lawsuit alleging that Baptist Health System Inc., of Birmingham, AL, was in violation of its federal tax-exempt status for charging uninsured patients rates higher than those paid by insured patients or government programs.

The decision confirmed a federal district court's October 2004 decision that the charges were barred by previous state court litigation. The court also stated that EMTALA claims had been properly dismissed because the statute of limitations had expired.

The court added that there was "simply no indication Congress intended EMTALA to address hospitals' bill collections practices."

In the lawsuit, the plaintiffs alleged that Baptist Health, the largest health care provider in Alabama, was contractually bound by its tax-exempt status as a charitable organization to provide charity care to uninsured individuals, but breached that contract by its charging practices.

The March 9, 2005, ruling was the first issued by a federal appeals court in a series of lawsuits filed across the country beginning in June 2004 attacking not-for-profit hospitals' tax-exempt status under Internal Revenue Code Section 501(c). ▼

HQA survey planned on patients' perceptions

Facilities that post performance data on the Hospital Quality Alliance's Hospital Compare website (www.hospitalcompare.hhs.gov) plan to begin collecting data from a new national survey on patients' perceptions of hospital care, with the first public reporting of results scheduled for late 2007.

The Hospital Compare site now enables patients and families to compare the performance of the nation's acute care hospitals on 20 quality measures for care provided to adult patients since 2004 for heart attack, heart failure, pneumonia, and the prevention of surgical infections.

In the latest Hospital Compare posting, for the fourth quarter of 2005, roughly 4,200 hospitals provided information on the 18 measures for heart attack, heart failure, and pneumonia. In addition, 1,349 hospitals provided data on two measures for surgical infection prevention added to the site in September 2005. ■

Correction

In a story that ran in the March issue, "Cross-industry perspective touted as care solution," the e-mail address for Eric Labe, senior vice president for the Dallas-based consulting company Thomas Group, should have been elabe@thomasgroup.com.

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

Administrative simplification enforcement rule in effect

Rule reinforces HHS approach to enforcement, experts say

The Department of Health and Human Services published the final enforcement rule for all HIPAA Administrative Simplification rules with an effective date of March 16, 2006. The final enforcement rule applies to the HIPAA EDI, privacy, and security rules, and the HIPAA unique identifiers.

Officials with the Segal Co., a benefits consulting firm, say the final rule reinforces the department's basic approach to enforcement — it will rely on complaints to identify violations, seek voluntary compliance through informal means, and provide technical assistance to help covered entities comply. It only will open a process that could lead to civil money penalties if a complaint is not resolved informally.

To open a process leading to monetary penalties, HHS must issue a "notice of proposed determination" that includes, among other things, a description of an alleged violation and the amount of the proposed penalty. The department has the authority to assess a penalty of up to $100 per day for each violation (a maximum of $25,000 per calendar year for identical violations).

Factors affecting the amount of a proposed penalty, according to Segal's *Capital Checkup*, are the nature of the violation, the circumstances (including the consequences) of the violation, the degree of the covered entity's culpability, the covered entity's history of compliance or noncompliance with the Administrative Simplification rules, and the financial condition of the covered entity.

Generally, the rule says a covered entity is liable for the acts or omissions of any agent, including a work force member, acting within the scope of the agency. But there is an important, limited exception for business associates. Segal's analysis says a covered entity is not liable for the acts or omissions of business associates if (1) the covered entity has a written business associate contract in place with that business associate and the contract complies with the applicable HIPAA privacy and security rule requirements, and (2) if the covered entity knew of a pattern of activity or practice of the business associate and the covered entity took reasonable corrective action.

Seattle technology attorney **John Christiansen** tells *HIPAA Regulatory Alert* he was somewhat surprised that the violation definitions in the new law are stronger than had been expected and have the potential for greater penalties.

The bottom line for organizations

While acknowledging that the Department of Health and Human Services intends to remain complaint-driven in its enforcement approach and work cooperatively with entities that are making a good faith effort, Christiansen says the department could use the concept of continuing violations to rack up huge civil monetary penalties if necessary to make a point.

"It's clear they are not funding investigators and responders well and so will remain complaint-driven," he says. "But they have a lot of leverage if they do go after a problem."

Christiansen says he also can see the strengthened violation definitions being used by trial attorneys involved in commercial disputes in which HIPAA violations are among the concerns being raised. "If I were litigating, I could write quite a brief now that we have this much specificity," he says.

The bottom line for organizations, he says, is the need to make a good faith effort to comply with the rules. "If you are acting in good faith, the department is supposed to meet you and

work with you collaboratively," he explains. "But if something major happens, regulators may see a need to intervene and have a lot at their disposal."

Christiansen says the final rule is an improvement of the draft due to the greater clarity and specificity that was included.

Contact John Christiansen at (206) 301-9412 or e-mail john@christiansenlaw.net. ■

Survey suggests shift toward long-term benefit

55% of providers compliant with security standards

The latest U.S. Healthcare Industry HIPAA Survey sponsored by the Healthcare Information and Management Systems Society and Phoenix Health Systems indicates participants in the health care system view the HIPAA privacy and security standards as building blocks for web-based communication structures rather than simply a compliance burden.

"Most states are either developing or considering involvement in a regional health information organization," the survey says, "for the purpose of electronically exchanging health information across defined regions while still protecting patient privacy and ensuring data security…Individual health care organizations are internally institutionalizing the concept of a secure health care environment that protects patients' rights without sacrificing or interfering with quality care. They are also incorporating these principles into the fabric of new community health networks that streamline and enhance the continuum of care. Many organizations are expanding their use of electronic transactions through these infrastructures, as federally required standardization begins to deliver on its long-standing promise of administrative simplification. HIPAA's impact on the health care industry is evolving from 'compliance' to an emphasis on new, electronically based opportunities for better communications across the continuum of care, and greater patient safety, cost-savings, and overall efficiency."

Participants in both the payer and provider surveys indicated HIPAA implementation has resulted in greater attention to patient privacy and data security by their employees and increased consumer confidence. Some 22% of providers are implementing return-on-investment initiatives related to HIPAA, with 88% of them expanding use of standard electronic transactions. Other initiatives include adoption of computerized practitioner order entry and conversion to electronic medical records.

Some 55% of providers reported compliance with HIPAA security standards, along with 72% of payers. The majority of non-compliant organizations projected full implementation of security standards within six months, although the report authors noted that group gave a similar time projection in the summer 2005 survey. Data security incidents continue to plague at least one-third of both payers and providers.

HIPAA transaction use growing

Adoption of HIPAA transactions has increased steadily over the last year and, as of January 2006, 84% of providers and 73% of payers reported being able to conduct all HIPAA standardized health care transactions. Some 67% of payers said they were actually conducting all HIPAA-required transactions, and 66% of providers reported conducting more than one-half of the standard transactions.

The report said privacy compliance levels remain consistent with previous survey results over the last two years — 80% of providers and 86% of payers reported in January they had met privacy rule requirements.

"It can be inferred that a core group of about 20% of covered entities is either unable or unwilling to implement federal privacy requirements," the authors said.

But even among compliant organizations, there are implementation gaps in certain areas, including establishing business associate agreements, monitoring internal privacy compliance, and maintaining an accounting of disclosures.

The incidence of privacy breaches in organizations has remained flat but high at 60% over the past six months. The percentage of payers reporting privacy breaches increased from 45% in July 2005 to 66% in January 2006. The majority of organizations experienced between one and five such breaches, but more than 20% experienced six or more.

Download the survey report from www.hipaadvisory.com/action/surveynew/results/winter2006.htm. ■

Info-Tech Research Group says HIPAA is 'ineffective'

With only one enforcement criminal conviction recorded since 1996, HIPAA is failing to meet its mandate, according to Info-Tech Research Group. "HIPAA is a toothless tiger," says Info-Tech analyst **Ross Armstrong**. "The first problem is that HIPAA is complaint-driven, and complaint-driven enforcement doesn't work. The second problem is that in the one HIPAA-related conviction that has occurred, only the individual was charged and not the organization itself. If HIPAA is to be truly protective and useful, health care entities and their executives must be held accountable in the same way that Sarbanes-Oxley holds CEOs and CFOs responsible."

Armstrong also questions the government's commitment to enforcing HIPAA, noting a Government Accountability Office (GAO) report that the FBI can't account for all of the $379 million it was given from 2000 to 2003 to investigate HIPAA-related frauds.

Some of the money reportedly was shifted to counter-terrorism efforts, but no one could verify that the rest was properly spent on HIPAA, the GAO said.

"One conviction that netted $9,000 in penalties hardly seems worth an investment of over a third of a billion dollars," Armstrong says. "Without proper government agency oversight, it comes as little surprise that there has been only one HIPAA conviction."

Armstrong tells *HIPAA Regulatory Alert* the difference between aggressive enforcement of other information technology-related laws and HIPAA is striking.

"There's been a lot of enforcement success under Sarbanes-Oxley and the Fair Credit Reporting Act," he says, "with a lot of revenue coming to the government. But because HIPAA is complaint-driven, no one is held accountable for privacy breaches."

The one criminal conviction involved a charge by the victim against a health care worker for identity theft, according to Armstrong, and no action was taken against the covered entity for which the convicted person worked. "If HIPAA is to be truly protective of privacy," he says, "entities also must be held accountable."

Armstrong refers to surveys by the Healthcare Information and Management Systems Society and Phoenix Health Systems indicating there still is a significant amount of non-compliance with HIPAA requirements.

Covered entities, he states, say there is no adverse public relations effect in not complying with the law and also little fear of government action against them. "There are lots of potential penalties [in the enforcement rule]," he says, "but if they are not being enforced, no one cares."

Armstrong says Info-Tech's consulting business does a lot of work in health care but rarely is asked to work on HIPAA issues, another signal to him that there is little concern.

Contact Ross Armstrong at (888) 670-8889. ■

MGMA concerned about e-claims standards

Group urges incentives for providers

The Medical Group Management Association (MGMA) has raised concerns about electronic claims attachments with federal officials.

In a letter to Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan, MGMA said its members support administrative simplification and believe that, once properly implemented, e-claims attachments can streamline an important billing transaction for medical group practices. It raised 11 general issues for consideration:

1. Standards should be flexible and scalable. MGMA said any standards for electronic claims attachments should take the wide variety of clinical specialties and settings into account.

"The final standard must be both flexible and scalable to encourage adoption by both small and large health care organizations and physician specialties processing both low and high volumes of claims attachments," it said. "Flexibility will allow doctors to consider critical factors such as clinical quality, safety, efficiency, and integration with existing practice management software and electronic health record systems when making an investment."

2. No undue burdens on providers. MGMA said it is critical that CMS develops a final rule that doesn't impose undue financial burdens on physician practices.

3. Promote the security and privacy of patient

data. MGMA said electronic claims attachments must maintain HIPAA security and privacy standards as part of their core features and CMS should provide guidance on the critical issues surrounding the minimum necessary provision of the privacy regulation.

4. Incentives for providers. The association calls for realigning incentives by promoting appropriate public and commercial reimbursement programs. MGMA said it has supported the concept of a federal program of tax credits for physician investments in health technology that could serve as a significant incentive. Also, a federally guaranteed loan fund for physician health technology investments, coupled with loan forgiveness for service to medically underserved populations, could be an effective stimulus to e-health adoption.

5. Technology savings accounts. MGMA wants the federal government to explore methods to assist medical practices in acquiring health information technology. It suggests technology savings accounts would provide a reduced level of taxation for funds designated for practice health information technology and says such accounts could enable group practices to pay for current expenses and save for future qualified health information technology expenses tax-free. Unspent account balances could accumulate interest.

6. Stark regulation safe harbor. According to MGMA, anti-kickback and self-referral concerns prevent some health care organizations from offering free or discounted technology to medical practices.

The association wants government approval of legal protections, such as safe harbors and regulatory exceptions, to facilitate health technology implementation.

7. Development of clinical and administrative crosswalks. CMS should develop and freely make available crosswalks between ICD, CPT, and LONIC code sets, MGMA says.

8. Staggered compliance dates. MGMA calls on the federal government to stagger implementation dates to give clearinghouses and health plans time to upgrade and test systems before provider information takes effect. It says piloting of the e-claims attachments standard should be completed before full national implementation to identify and correct problems.

9. Development of a national rollout plan. CMS should initiate a national rollout plan taking into account requirements of each impacted industry sector, MGMA recommends.

10. Continued consultation with the physician practice community. MGMA encourages CMS to continue its outreach to physicians to ensure their requirements and concerns are addressed.

11. Industry outreach. MGMA says physician practices will need substantial education before they are fully aware of and comfortable with e-claims attachments. And CMS also should be communicating with the software vendor community to encourage them to move forward with product development as quickly as possible.

More information is available at www.mgma.org. ■

Ohio court puts state open records law over HIPAA

The Ohio Supreme Court says the state's open records law takes precedence over HIPAA privacy requirements. The court ruled in a case brought two years ago by the *Cincinnati Enquirer* when it sought to compel the city health department to disclose addresses of homes and businesses ordered to remove potentially hazardous lead paint.

"Ohio has a long-standing public policy committed to open records," wrote Justice Terrence O'Donnell in the unanimous decision. "The Cincinnati Health Department and its commissioners have a clear legal duty to make the lead citations available." The department had argued that releasing the information would violate HIPAA privacy regulations because lead citations are based in part on blood tests of children.

Lawyers for the newspaper argued that the more than 300 lead citations the newspaper requested were public records that revealed a potential threat to public health.

They said the citations did not include names of children tested, Social Security numbers, or any other personal medical information. The newspaper also argued the health department, unlike hospitals and other providers, is not covered by HIPAA.

While the state open records law says a record is open unless prohibited by federal law, HIPAA says medical records are private unless state law requires them to be open. The seven Supreme Court justices decided that when the two levels of law conflict, state law should be followed. ■