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Informing patients up front about 'out of pocket' costs aids POS collections

Mayo tool gives fast results for contracted, self-pay accounts

A new system for calculating patients' financial responsibility for care at the Mayo Clinic in Jacksonville, FL, is part of an organization-wide review of the revenue cycle, with an eye on gaining efficiencies while enhancing customer service, says **Kelly White,** MBA, section manager, patient financial services.

"There's a direct correlation between increasing service to patients and being able to tell patients [before treatment] what they will owe — so you don't hear, 'You never told me. . .' on the back end," she notes. "We want to do this for all patients, prior to service. Currently our options are face-to-face or over the phone, but in the future it could be via the web on a patient portal."

For the past two years, White says, the Mayo Clinic has been looking at business process opportunities at its three locations — in Scottsdale, AZ; Rochester, MN; and Jacksonville — in an effort to "bring the three organizations together and have them learn from each other."

The revenue cycle is one of several areas — others include human resources and materials management — being reviewed, White adds, and her responsibility has been to oversee the patient access component.

One of the discoveries has been that informing customers upfront of their out-of-pocket costs is not only integral to providing the best service, White points out, but is crucial in view of the attention given to price transparency and the handling of self-pay and charity care patients.

While the Scottsdale and Rochester facilities had been using their own homegrown products to estimate the cost of services for self-pay patients, she says, the process involved was laborious and time-consuming.

"They had put together, based on historical activity, the cost of, for example, a total hip [replacement]," White explains. "They had to look up codes and based on those, go in and determine fees and then store

them electronically, so the next time [the price was needed] they could go in and check it."

The downside to the process was that since fees change continually, depending on the market and the product, it was "a maintenance nightmare," she says. "They were always updating fees, because the surgeons would start using different techniques or the surgical times would change, so keeping an accurate package [fee] was difficult."

Also, the homegrown products didn't have the capability of having that estimate "hit against our contract" with a particular insurance company to determine an out-of-pocket percentage based on the contractual rate, White notes. "The homegrown systems were for self-pay patients, but we [also] wanted to be able to [inform] our contracted patients."

With that goal in mind, the clinic selected a vended product and began the implementation process. Because hospital and physician operations are integrated at the Mayo Clinic, that process was more challenging than it otherwise would have been, she says. "The coding is different and the calculation of the final estimate is different."

While the facility component has been operational at the Jacksonville location since August 2005, the professional piece was expected to be in place by July 2006, she adds. "We're slated to roll out to Scottsdale by year-end and to Rochester sometime in 2007."

The results have been gratifying and dramatic, White says. "We have recognized a significant reduction in the amount of time it takes to complete an estimate. What used to take 35 to 40 minutes now takes an employee five to 10 minutes.

"We are able to offer additional service because we are freeing up that time," she notes. "Some of that is spent providing additional financial counseling services."

Before, White adds, staff would look up the code for the pertinent procedure, and then get the fee associated with that code from the hospital's chargemaster or from historical information.

Contracted patients would be given the code and told that they must contact their insurance company to get the out-of-pocket amount, whether copay, deductible, or co-insurance. Now, with the new system, White points out, "we can create the estimate, hit against the contract, and come back and tell the patient much more accurately [what is owed]. It takes those patients out of being in the middle of us and the insurance company."

However, if the patient is insured but not contracted, she explains, "the person is still in the middle. We give the estimate, and the patient goes back [to the outside insurance company] and says, 'I'm having a total hip [replacement]. Here is the code. What is your reimbursement rate?'"

With the time gained through use of the new system, however, staff are able to provide those customers with a higher level of service, White says, often assisting them in communicating with the insurance company.

There is improvement in the accuracy of the estimate, she adds, because it is based on historical claims data that take into account even the

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Editorial Questions

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

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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).

individual surgeon and the time he or she takes to do a procedure.

"We can pull the historical claims and take the median of those claims and that is [the estimate] we give," White notes. "We give patients an estimated price range, and they are much happier if we come in below. If we come in above, that's a big dissatisfier."

At present, the clinic is using the new system primarily for self-pay patients, she says. "It is giving a good picture of what they will owe, and we do expect payment upfront.

"We are starting to roll it out with contracted patients, with a high expectancy that out-of-pocket estimates will be very accurate," White adds. "The goal is that based on that, we will be able to collect [upfront] the amount owed by the patient."

Having the accurate and timely pricing data the system provides is crucial as patients incurring greater and greater out-of-pocket costs start to comparison-shop for health care, she suggests. "Having tools to make that information easily available is imperative.

"Before, it was such a labor-intensive, time-consuming process to create an estimate — especially when facility and surgeon are combined — that we haven't done it very proactively," White adds. "This gives us the flexibility to more readily provide that information."

'Advance EOB' touted

As part of a plan to move collections at its six hospitals to the point of service or before, Cincinnati-based Health Alliance is working toward the widespread use of what revenue cycle operations executive **Patrick McDermott,** MBA, has dubbed the "Advance Explanation of Benefits."

To achieve that end, his organization also sought a timely and accurate method for telling patients what they owe before a service is performed.

"Typically, what you get from an insurance company is an EOB, an 'Explanation of Benefits,' but it comes at a time when it is the least useful to the patient," McDermott points out. "Sixty or 90 days after an inpatient stay, patients are not really interested in financial information anymore. They've already received their CAT scan or expensive medical implant, and other bills are at the top of the queue.

"So why don't we move toward the 'Advance EOB?'" he suggests. "Tell the patients what their benefit situation is, how much they owe, and try to set up a payment plan prior to or at the point of service."

The proposal takes "a rotten idea" — the insurance company EOB — and "turns it on its head," McDermott continues. "You can't read them, can't understand them, but what if you were to get that [information] as you were registering for service, and had the opportunity to ask some questions?

"You could call the insurance company and ask, 'Why are you paying so little, why is the copay so high?' You'd be a lot more interested prior to service."

Calculating the cost

To meet the technological challenge of accurately estimating the patient's bill and knowing what the insurance company will pay, McDermott says, Health Alliance is working with Innovative Managed Care Systems (IMACS), a Dallas-based contract management firm.

Its web-based CarePricer technology uses the hospital's chargemaster, managed care contracts, and claims history to calculate the expected payment from the insurance company.

In 2005, McDermott notes, Health Alliance implemented a point-of-service collections program in the emergency departments (EDs) of all six hospitals. "We started there because ED copays are well-defined on the insurance card. We received little to no [negative] customer feedback, because customers are accustomed to paying copays at the physician's office, but they do want to know if it is exact.

"If they're confident the figure is accurate, they'll pay," he adds.

In late 2005, the health system started talking to IMACS about the ability to compute co-insurance for inpatient and outpatient stays when "the card doesn't say how much you owe," McDermott says.

What makes the IMACS system different from other tools that address out-of-pocket liability, says **Julie Waddell,** CarePricer product owner, is that "we take providers' historical claim data, all the charges they bill to all kinds of payers, all the UB92 data and do an in-depth analysis in order to create 'service packages.'

"So we take the CPT code or description or the DRG [diagnosis-related group] or chief complaint and look at the population of claims associated with it — from the perspective of physician, age

of patient, etc. — and create a package of services," Waddell adds. "Then we apply the terms of the contract."

The product was introduced in 2004 at the request of a provider client that needed to provide uninsured patients with an estimate based on a contract with the government, she notes. From there, Waddell says, the company migrated in 2005 to an all-payer version.

About 80 health care facilities are using the CarePricer at present, she says, with a portion of those employing just the uninsured version.

Health Alliance, which was one of the first two health care providers to pilot the version for insured patients, began inpatient preservice collections at its facilities in January, notes McDermott. "Because CarePricer is an Internet-based tool, we were able to grant access to the admitting departments at all six hospitals."

The results have been very positive, he says, with increases in preservice collections in January, February, and March.

"We have a lot of kinks to work out in terms of solidifying policies and scripts and measurements," McDermott says, "and we're working closely with CarePricer to develop some measurement and reporting tools."

[Editor's note: Kelly White can be reached at (904) 953-2479 or by e-mail at white.kelly@mayo.edu. Julie Waddell can be reached at (972) 755-6347 or by e-mail at jwaddell@imacs.com. Look for more information on the implementation of inpatient preservice collections in Health Alliance admitting departments in the next issue of **Hospital Access Management**.*]* ■

AMs take different tack at small, rural hospitals

'It takes hands-on planning every day'

At Grande Ronde Hospital in La Grande, OR — and at other small, rural facilities throughout the nation — there often is a slightly different twist to the way the access department operates.

Grande Ronde, a rural hospital in eastern Oregon that serves mostly patients who are on either Medicare or Medicaid, is part of the Critical Access Hospital (CAH) Program, created by the 1997 Balanced Budget Act as a safety net device to ensure access to health care services for Medicare beneficiaries in rural areas, notes **Judy Washbond**, admitting manager.

As such, the hospital is certified under Medicare Conditions of Participation, which are more flexible than those for other hospitals, and receives cost-based reimbursement from Medicare and Medicaid. The Medicare Prescription Drug Improvement and Modernization Act increased that reimbursement to cost plus 1%, and gave CAH facilities the flexibility to designate up to 25 beds as acute care inpatient beds.

"If we don't follow the rules, we lose our status," Washbond says, "so it takes hands-on planning every day."

There are a number of issues associated with operating a small, rural hospital, notes **Keith Mueller**, PhD, director of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis at the University of Nebraska Medical School in Omaha. Among those, he says, is the challenge of providing adequate communication services with limited staff. **(See related story, p. 68.)**

Because of the 25-bed limit on acute care admissions, Washbond has reason to keep an even closer eye on patient intake than her peers at other kinds of hospitals.

"I look at the census every day to see who was admitted the previous day," she says. "I call on those admits and check insurance eligibility, and also get the precertification requirements and pass those on to case management."

Case managers depend on her to provide this service, Washbond says, because they don't have a secretary or other administrative help.

"I work very closely with case management every day, making sure patients are placed in the right areas and that there are timely discharges," she says. "If we get a call from the [outpatient] surgery center about a patient with complications and they say, 'We need to admit,' flags go up. Do they really need to be admitted?

"You have to think creatively," Washbond adds. "If we have a person in the emergency department [ED] that needs to be admitted, we ask, 'Can this patient be on observation status?' If so, he can be based in an ED bed or in outpatient surgery — where there are heart monitors — and we can monitor his chest pain and observe his condition."

The 13 admitting employees cover inpatient and ED admissions and outpatient diagnostics and surgery, she says, as well as operating the hospital switchboard. They also perform such tasks as recovering medical records after hours,

communicating with on-call physicians, and monitoring emergency calls, Washbond adds.

"We have a radio system that is on all the time to allow us to listen to 911 calls," she says. "We hear a tone that lets us know an ambulance is going out on a call. We hear the 911 operator talking to the [paramedics], so we know the address, and we have the operator call us with the name."

By the time paramedics arrive on the scene and call the hospital to make a report, Washbond says, admitting staff often have already done an ED quick admit.

If the person is an existing patient, which is usually the case, the staff have access to the necessary information, she notes. "If not, [admitting staff] are standing by to hear the medical report from the paramedics."

When that call comes, admitters immediately summon a nurse — located just a few steps away — to hear the medical report, she explains. Although admitting staff used to record the information, Washbond says she changed that process when she became manager.

"I was uncomfortable with that, as [admitters] are not [clinically trained] and often would misspell names or not be entirely accurate," she explains.

Patients sign in for service

The department handles registrations differently than most facilities, Washbond says, asking all patients — including those seeking care in the ED — to sign in upon arrival at a customer service/reception desk in the main lobby.

Patients write their name, birth date, and primary care physician on a slip that includes a list of all ancillary departments, she adds.

"They check the appropriate department, put the slip in a tray, and we take them in order," Washbond says. It's all done on paper, she notes. If one of the slips is for an ED patient, the employee who comes to collect the slips doesn't enter into a dialogue with the person, but simply calls the ED admitters and gives them the information.

A staff member in the ED admitting area, which is next to triage, opens a window, places the slip in a box, and pushes an alarm, Washbond says. "The nurse turns off the alarm, takes the slip, and goes to the waiting room to call for her patient. If there is more than one person [seeking emergency care], she sees from the slip who is the most acute.

"At that point, my admitting staff go into the computer and do an ED quick admit," she adds. "It's three pages, not 17, and doesn't go into financial issues at all."

The quick admit is done so that a chart can be created quickly — also by admitting employees — which allows the nurse to place orders, Washbond says. "Sometimes [patients] don't come back to us from triage. We make up the chart, take it back to the ED, and enter the patient in the ED log and department register. Then we put the chart in a file [holder] that is bracketed to the wall, and the nurse takes it when she is ready to call a patient."

While they are waiting. . .

At many hospitals — including Grande Ronde — the time patients spend in the admitting process tends to "get rolled up into the whole experience of having to wait," Washbond points out, with the general assumption on the part of other departments that admitting is to blame for any delays.

"They can't say that here," she says, noting that she recently collected statistics and tracked times to show that slowdowns in patient throughput at Grande Ronde were not tied to the admitting process, but actually occurred once the patients were in the treatment room waiting for a physician.

As part of a team focused on improving patients' experience in the ED, Washbond was instrumental in having small plasma televisions placed in all treatment rooms. "People are not just sitting in an empty room with nothing to do, so they're not as conscious of the wait."

The ED quick admit process also came out of that team's work, she says.

Grande Ronde deals primarily with repeat patients, Washbond notes. "Most patients have a history with us, but if it is a new patient, we have a laptop that we roll into the room to get the information."

If a patient isn't taken back for treatment immediately, he or she comes back to the admitting area, where an employee picks up the ED quick admit and expands upon it, she explains. Then the patient is sent to the waiting area until a bed is available.

At Memorial Hospital, a critical access facility in Seward, NE, patient volume doesn't support having access personnel in the ED 24 hours a day, says **Melissa Eberspacher,** business office director, "so we have trained nurses to take registration information after hours."

Because their first priority, understandably, is patient care, she notes, "that leads to a little difficulty in payment turnaround or collections. It's difficult to expect the lengthy information we try to gather — good solid phone numbers, demographic stuff — all to be filled by nursing staff."

While there can be days and days when the ED is very quiet, Eberspacher says, at other times "we could be swamped" because of the hospital's proximity to an interstate highway and to the city of Lincoln.

ED nurses traditionally have handwritten registration information that then is entered into the system the next day by access staff; but they now are being trained to use the admission software themselves, she adds. "We are in transition with that.

"Admitting in the computer had to be mandatory because [admitting software] is tied to our electronic order entry product," Eberspacher says. "They have been really good about it and very receptive because getting [the data] into the system is good for them as well."

Difficulties come when situations require a lot of "stat" orders, she says. "Where [in the past] they might have just been jotting down the date of birth and a few other pieces of information, now they have to figure out the routine for getting through the whole [registration process]."

A quality improvement team has been working to facilitate that process for the past three months, Eberspacher notes. "Right now we're in the middle of creating a competency test. It's not a scoring test, but more about walking them through [the process] until they pass.

"We'll make sure we have something in place as new staff come in," she says, "and we may do it annually as a reminder."

Advance directive focus

Another way in which Washbond at Grande Ronde Hospital differs from many of her access counterparts is her handling of the dissemination of information on patients' rights and responsibilities and advance directives, she points out. Her staff offer the information to all patients, who are asked to initial a form, of Washbond's design, that references advance directives and patient rights on the same page as the terms and conditions of admission. **(See form, p. 67.)**

"With all the rules that are out there today, this is a huge issue," she says. "If you have a complaint by a patient regarding anything happening in a hospital setting, it may go to the [state health department], and the first thing [investigators] ask the patient is, 'Were you given [information on] patient rights and responsibilities?' They want to make sure the patient is aware of how to make a complaint."

It was her idea to have patients initial the form, Washbond says, so that it can be used later to show that the information was offered. "I particularly wanted an acknowledgement that was undeniably made by the patient and not by my staff. We keep it for Medicare patients or if the visit becomes part of the patient's medical record."

The advance directives also can be referenced by nurses, she adds, who are supposed to re-address the issue of whether patients have received that information. "This way, it can be an affirming acknowledgement, rather than a repeating of the question.

"Other facilities [offer the brochure] only to inpatients, surgery, and ED patients, but I do it for everybody," Washbond says. Widespread distribution of the advance directives information is especially important, she says, because "the greatest opportunity to capture people is with outpatients."

"Nobody is ever upset about it," she adds. "We don't get complaints, and we hand out a lot of these." Besides, Washbond notes, handing out the information on advance directives to outpatients causes less stress than if it's offered just prior to surgery or another inpatient admission.

In the latter cases, she says, "the patient's reaction to being asked about [end-of-life issues] may be, 'Do you know something I don't know?'"

Before a recent remodel, the admitting staff all worked in one big office, Washbond says, but that has changed in the wake of the Health Insurance Portability and Accountability Act (HIPAA), which requires that patients be registered in a way that protects their privacy. Now, there are two registration rooms, enclosed about two-thirds of the way down with glass, so that admitters can see what's going on in the lobby as they register patients, she adds.

Washbond, who helped redesign the space, can see the registration room and part of the lobby desk from her office. "I also have a monitor in my office that allows me to see the front door. If both [admitters] are busy and I'm available, I go out to help. We like to respond to people personally."

There are no transport employees at Grande Ronde, so when possible admitters go out front and meet certain patients with a wheelchair, Washbond says. "[Cars with incoming patients] pull up right out front, so we can see if someone

Grande Ronde Hospital

ACCOUNT NO.

MEDICAL REC. NO.

NAME

BIRTHDATE

TERMS AND CONDITIONS OF SERVICE *Stamp Patient card Here*

CONSENT FOR RELEASE OF INFORMATION

RELEASE OF INFORMATION TO PRIMARY CARE PROVIDER, REFERRING PROVIDERS, INSURERS AND PROFESSIONAL REVIEW ORGANIZATIONS: I understand and consent that health information received or created in the course of the individual's health care at Grande Ronde Hospital will be used or released for treatment, payment, and health care operations as described in the Grande Ronde Hospital Notice of Privacy Practices. I have been provided a copy of the Notice of Privacy Practices.

STATEMENT OF FINANCIAL RESPONSIBILITY

FINANCIAL AGREEMENT/NON COVERED CHARGES: I agree to pay Grande Ronde Hospital for services received. I understand I am financially responsible to the hospital for charges not covered by my insurance or other payers, which may include a deductible and co-payment that are expected to be paid at the time of service. If insurance payment is not received, the balance in full becomes my responsibility. Accounts are payable in full at the time of billing. I agree to promptly pay any charges not immediately (within 30 days) covered by insurance(s). If this account is referred for collection, I agree to pay reasonable attorney fees and collection expenses, including any accrued interest. We do not bill nor do we refund for balances under $5.

ASSIGNMENT OF INSURANCE BENEFITS: I assign insurance benefits to the hospital. I transfer my right to payments due to me from insurance to the hospital.

FOR MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII for the Social Security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ **I acknowledge receipt of *"Important Message from Medicare*"**
Initials

FOR CHAMPUS/CHAMPVA/TRICARE BENEFICIARIES ONLY: I request payment of authorized benefits made on my behalf for any services by the hospital, including physician services. I authorize any holder of medical or other information about me to release to Champus/Tricare and its agents any information needed to determine these benefits or benefits for related services.

_____ **I acknowledge receipt of *"Important Message from Champus"***
Initials

PERSONAL VALUABLES: The hospital encourages patients to leave valuables at home or with a family member. The hospital maintains a safe for storing patient valuables during their stay. The hospital will be responsible ONLY for those items documented and committed to safekeeping.

ADVANCE DIRECTIVES/PATIENT RIGHTS:
Initial correct response

I have an Advance Directive on file with this hospital? **Yes_____ No_____**

I have received written information about Oregon's Advance Directive law called *"Making Health Care Decisions".* **Yes_____ Declined _____**

I have been informed and provided information about my Patient Rights. **Yes_____ Declined _____**

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS

Patient **Date** **Parent, Guardian, Responsible Party, Legal Representative**

Source Grande Ronde Hospital, La Grande, OR.

is having a struggle getting in, or if there is a direct admit to the intensive care unit. We also will transport elderly patients to the ancillary departments for their appointments."

Staff schedules tweaked

Seven years ago, when Washbond became manager after 10 years as an admitting representative, she made some changes. "Shaking up things was my way of taking control of the staff," she notes. "I strongly believe in controlling what goes on and I'm aware of what's going on. People do better with clear expectations, when they know what to do in every scenario."

Staff members had tended to become attached to certain areas or duties, even though all are trained to handle the full gamut of responsibilities, Washbond says. "In the beginning, I would say, 'I want you to switch with your partner every two hours.'"

These "partners," she explains, included the ED admitter and the switchboard operator, who work within a few feet of each other, and the two people in the main admitting area. At times there may be three employees in main admitting, Washbond adds, when shifts overlap.

That directive wasn't successful though, she adds, because employees found themselves in the position of trying to persuade their co-workers to swap duties with them. "Then I made a schedule, and that seemed to work. They accepted it extremely well. Now they rotate every couple of hours."

Help patients understand their Medicare coverage

Medicare copays may be higher

Helping patients understand their Medicare coverage in the wave of alternative plans that are being offered is a service that all patient access employees should be prepared to provide, suggests **Keith Mueller**, PhD, director of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis at the University of Nebraska Medical School in Omaha.

"What I've heard has been happening lately is that people will sign up for Medicare Advantage plans, not realizing that they have just changed everything about their coverage from what it was before," Mueller says.

"Before, there was a minimal copayment, now there may be a larger one," he adds. "Under traditional Medicare, it may not matter where you go [for care], but under Medicare Advantage, it may cost more depending on where you go."

However, discussing this issue with patients, can lead to "a real sensitive area of counseling," Mueller points out. "You don't want to say, 'It costs more money for you to come here than to go [to the hospital] down the highway.'"

Instead, he recommends the access employee say, "I see that with the coverage you had before, there were no copays, but now you're responsible for $1,500. It might be less if you go to a different hospital."

At the same time, he says, "you don't want them to get the idea that there is a difference in care quality at the other hospital."

Mueller, who works as an advisor on Medicare issues, says the "Important Message From Medicare" that patients are given "doesn't make that clear. This particular issue hadn't even appeared to me until recently."

Mueller notes that one of the challenges with communicating this and other messages at the small, rural hospitals with which he works is that staff don't have the support systems to draw on that exist at larger facilities.

"In talking with the press about small, rural hospitals, they complain that they can't get patient condition [reports]," Mueller says. "The problem is those hospitals don't have the resources to maintain their own legal staff and expertise so they can have a high degree of confidence that they are doing the correct things under the law."

They realize, he adds, that there could be civil and criminal penalties associated with not doing the right thing.

His advice to staff at these hospitals is to talk to their peers at comparable facilities. "Ask, 'Is someone in my state doing this differently?'"

During visits to rural hospitals, Mueller says, he often finds that something innovative is happening in a particular area at one facility, while 30 miles down the road, another hospital is struggling with the same issue.

"They don't talk to one another," he adds. "This is where networking activities [should] come into play. Ask your state association for help." ■

Her intent, Washbond explains, was to boost morale and reduce tension. "It helped create a more cooperative environment. It gets tiring to sit all day and admit ED patients. You might get resentful of someone in a less busy area. Or maybe you just enjoy answering the phone, but maybe your partner does, too."

(Editor's note: Judy Washbond may be reached at jaw01@grh.org. Melissa Eberspacher can be reached at melissaeberspacher@alltel.net.) ■

Dueling signage in the ED? Experts disagree

EMTALA intent debated

Should hospitals post signs advertising their intention to collect insurance copays and deductibles in the vicinity of the emergency department (ED), where they *are* required to display the rights of patients under the Emergency Medical Treatment and Labor Act (EMTALA)?

In doing that, are they sending mixed signals?

"If it conflicts with the EMTALA message, [the Centers for Medicare and Medicaid Services (CMS)] cites it as a violation," says **Stephen Frew**, JD, web site publisher (www.medlaw.com) and EMTALA specialist, "and a sign that says there are copay or insurance requirements conflicts with the idea that you will provide care regardless of means or ability to pay."

On the other hand, counters **Todd Taylor**, MD, FACEP, vice president for public affairs at the Arizona College of Emergency Physicians and an EMTALA compliance consultant, "there is nothing under EMTALA in regard to posting signage about copays or even payment for services that is, per se, a violation. The [law] is fairly clear about what is and is not allowed."

That said, "Do I recommend [hospital EDs] put up signs like that? No, I don't," he says.

"What you have to be careful about, what you need to ask yourself, is, 'What's the purpose of the sign?'" Taylor adds. "I don't think it serves a purpose because you still have to collect the copay. It's not a violation, but if you do an assessment of why you are doing it, there is no point."

Physician offices put up such signs, he says, because "people will walk in, see the sign, reach in their pocket, see that they have no money and leave." If that's the objective of such a sign in the ED, Taylor adds, "you do have a problem."

"Hospitals should assess the purpose and the anticipated outcome for any signage they post," he advises. "The ED is different than any other part of the hospital and health care in general when it comes to how you approach payment and billing. The common rules, or even common sense, simply do not apply."

Many times the incident that brings CMS investigators to a hospital turns out not to be a violation, Taylor notes, "but it opens the door to airing your dirty laundry. The best way to prevent that is never get cited in the first place."

CMS, he says, has cited hospitals for posting certain types of signs that in the agency's words "unduly discourage(d) individuals from remaining for further evaluation."

Taylor concurs with Frew who frequently advises, "Pay no attention to what CMS *says*, watch what they *do*."

The key, he says, is to "be innovative, but not 'clever.' Where I see hospitals getting into trouble is when an administrator thinks he or she has a new 'clever' approach. Invariably, that results in an EMTALA investigation and often citation and fines."

Most signs inadequate, Frew says

The easiest of all requirements associated with EMTALA is that hospitals post appropriate signs — "in the right places, in the right size, and in the right languages" — explaining patients' rights under the legislation, says Frew. Even so, he contends, two out of three hospitals he visits have either conflicting signs or inadequate signage.

Hospitals give several reasons for the lapses "but none of them are good enough," he says, including: "We forgot to put them up when we were finished. We did not realize we needed one there. We did not realize they had to be that big."

CMS, Frew points out, requires that signs including the following language be posted in all public entrances, registration areas, and emergency department treatment and waiting areas, including separate areas for obstetrics, psychiatry, and urgent care clinics where patients present on an unscheduled basis.

"It's the law. If you have a medical emergency or are in labor, you have the right to receive, within the capabilities of this hospital's staff and facilities:

"Necessary stabilizing treatment (including treatment for an unborn child) and, if necessary,

an appropriate transfer to another facility, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid.

"This hospital (does/does not) participate in the Medicaid program."

CMS requires that the sign be clearly readable from a distance of 20 feet, or from the expected vantage point of the ED clients. Signs are generally required to be about 18 inches by 20 inches, Frew says, and must be posted in foreign languages where applicable.

Signs in cubicles, for example, may be smaller, he adds, but still must be clearly visible. ■

AHA survey highlights ED overcrowding issues

Shortage of critical care beds cited

Half of the nation's emergency departments (EDs) are at or over capacity, and a majority of hospitals have reported time on ambulance diversion, according to the American Hospital Association's 2006 Survey of Hospital Leaders.

The most common reason given for diversion was not ED overcrowding, per se, although that was the second-most frequently cited issue, says **Caroline Steinberg,** vice president for trends analysis in AHA's Washington, DC, office, but rather the lack of staffed critical care beds, which leads to patients having to "board" in the ED until a bed is available. **(See chart, below.)**

Urban (68%) and teaching hospitals (75%) reported the greatest amount of time either at or over capacity in their EDs. **(See chart, below.)**

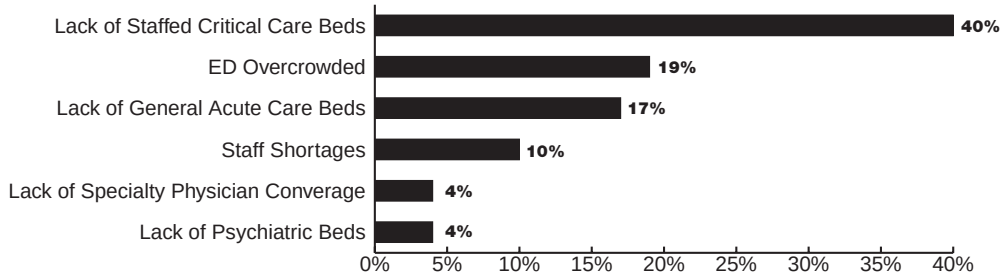
The survey was sent to about 4,900 hospital CEOs in late February via fax and e-mail, and data was collected through March.

Even when the demand for inpatient care was declining due to the pressures of managed care and the effects of hospital mergers, ED demand has never stopped growing, Steinberg notes, even as many hospitals and EDs have closed.

Those hospital closings have contributed to capacity constraints that are also increasing inpatient demand, a trend that has been somewhat unexpected, she adds. "There was a lot of downsizing and consolidation in the early '90s, and the thought was that we would continue to see declines in patient admissions."

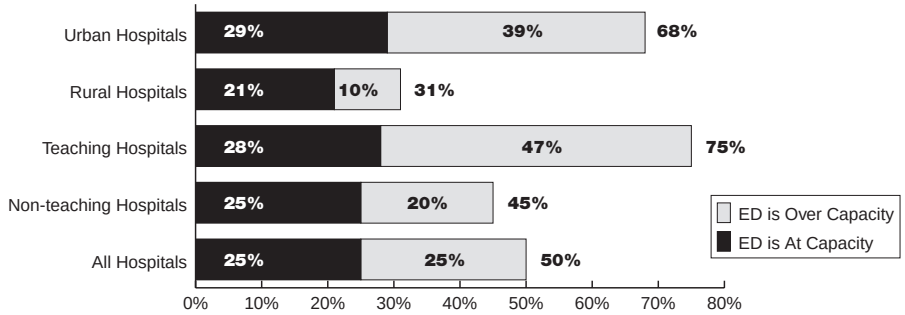
Also contributing to the ED shortage is a new

Percent of hospitals citing factor as No. 1 reason for ambulance diversion
January 2006



Source AHA 2006 Survey of Hospital Leaders

Percent of hospitals reporting ED capacity issues by type of hospital
2006



Source AHA 2006 Survey of Hospital Leaders

trend toward limited-service hospitals, Steinberg notes. "These are physician investor-owned facilities without EDs."

Outpatient visits, meanwhile, have been on an almost uninterrupted upward trajectory since 1990.

One of the most notable trends in outpatient care, Steinberg says, is the "massive migration of care outside the hospital, as increasing numbers of complex surgeries are moving to freestanding ambulatory centers and to physician offices.

"One of the concerns there is that those facilities tend to be less regulated than hospital outpatient departments," she notes.

The rate of increase in hospitals becoming part of health systems has gone up in the last few years, Steinberg says, but is less than in the mid-'90s.

"Managed care pushed a lot of integration and a reduction in capacity," she adds, "and there was the capital crunch with the Balanced Budget Act. Hospitals were suffering financially and one way to access capital is to merge."

However, she adds, "the pressure from managed care is less now and there is a limit to how many mergers you can have." ■

Imposters try to gain access using JCAHO name

Ask for ID, organization advises

It is apparently "imposter season" again for JCAHO inspectors, says **Joe Cappiello,** vice president, accreditation field services, for the Joint Commission on Accreditation of Healthcare Organization in Oakbrook Terrace, IL.

From early spring to early summer in 2005 there were around seven reported instances of imposters using the name of a JCAHO official to try to gain access to a JCAHO-accredited hospital, Cappiello notes. "Then [the occurrences] just went away. There were no reports for months."

But beginning in late March, he adds, there were suddenly two such events in California and another a week later in Wisconsin.

"They were all handled appropriately," Cappiello says. "We released [an advisory] to all our organizations and alerted the authorities. There is still no common pattern and no identified motive. That's really all I have — a mystery that continues."

Asked if he has any advice for access managers and directors, whose employees are often the first to greet hospital visitors, Cappiello says, "I would remind them that all Joint Commission surveys are unannounced, as of Jan. 1, 2006, so security and proper identification of surveyors is essential.

"Joint Commission staff will expect to be challenged when they arrive," he continues, "and [access personnel] should not hesitate to detain any person until they can can verify his or her identity."

In an e-mail alert, JCAHO advised accredited organizations to ask surveyors to show their ID badges when they arrive. Providers can verify their survey date and assigned surveyors on the JCAHO Extranet site.

The site also will contain a survey notification letter from Russell Massaro, MD, JCAHO executive vice president of accreditation operations, as well as the names, photographs, and biographies of the people who will conduct the survey, according to the JCAHO alert.

Hospital staff who encounter a possible imposter are asked to notify their local law enforcement authorities and call Cappiello at (630) 792-5757. ■

NEWS BRIEFS

Rule would require notice of noncovered services

The Centers for Medicare & Medicaid Services has published a proposed rule that would require hospitals to give all Medicare beneficia-

COMING IN FUTURE MONTHS

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- The latest on massive UAMS project
- An update on regulatory concerns

ries a standard notice of non-covered services the day before discharge.

The notice would be similar to those home health agencies and skilled nursing facilities must provide, and would include the patient's prospective discharge date, the date coverage ends and financial responsibility for continued services would begin, and the right to an expedited review and other appeals.

If the beneficiary wishes to dispute his or her discharge, the hospital or Medicare managed care organization would be required to deliver a more detailed notice that explains why the services no longer are required, according to the proposed rule's provisions. ▼

AHRQ study looks at admissions from ED

Fifty-five percent of admissions to the nation's community hospitals for conditions other than pregnancy, childbirth, and neonatal care begin in the hospital emergency department, the Agency for Healthcare Research and Quality reports.

More than one-quarter (26%) of the 29.3 million patients admitted through the ED in 2003 had heart or blood vessel diseases; 15% had respiratory diseases; 14% had digestive disorders; and 11% had injuries, according to the agency's Nationwide Inpatient Sample database.

Pneumonia led the top 20 specific conditions warranting hospitalization through the ED, with 935,000 admissions. Other leading conditions included congestive heart failure, chest pain, hardening of the arteries, and heart attack.

More information is available at www.ahrq.gov. ▼

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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**. ■

Number of competing insurers declining

A new study by the American Medical Association (AMA) shows growing evidence of health insurance market concentration across the country.

A single commercial insurer covered at least 30% of the HMO and PPO enrollees in 95% of the 294 metropolitan areas studied, and in 56% of the markets a single insurer covered at least half of the enrollees.

"Given the troubling trends in health insurance nationwide, federal regulators need to take a hard look at whether patients are being harmed as mergers and takeovers reduce the number of competing health insurers," said AMA board member James Rohack, MD. ■