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Access staff must work smarter, as high-deductible plans gain popularity

Financial counseling needs, insurance questions likely to increase

As the trend moves inexorably toward more consumer choice in medical care, access departments are likely to see an increasing number of patients with some version of what is known as a consumer-driven health plan (CDHP).

Along with CDHPs — simply defined as high-deductible health plans combined with tax-advantaged savings accounts — come some new challenges for frontline staff, industry observers say.

Access staff, they suggest, will be taking on greater responsibilities since more patients will need financial counseling or assistance before receiving hospital services. Another challenge will be distinguishing the different varieties of CDHPs and their accompanying requirements.

The benefits, proponents say, are that CDHPs provide a way for employers to offer health care plans for their employees at less cost, and for consumers to do more comparison-shopping for health care — thus potentially leading to more widespread coverage and reduced health care spending.

Opponents argue that, on one hand, the high deductibles will cause consumers to delay necessary medical care and, on the other, that hospitals' bad debt will increase as they try to collect those larger amounts for which the patient now is responsible.

"The federal government has been highlighting [CDHPs] as a way to make patients more price-sensitive," says **Rick Gundling,** FHFMA, CMA, vice president, product development for the Westchester, IL-based Healthcare Financial Management Association (HFMA). "Having them out there puts pressure on the health care industry to be more price-competitive."

Under the growing consumerism, Gundling notes, "part of the change is sharing more [financial] responsibility. A lot of employers are dropping [insurance coverage] altogether or looking for ways to make it less expensive for them."

Faced with the inevitability of increased financial responsibility on

the part of the patient — already evidenced by higher copays and deductibles in existing plans — HFMA's focus is on helping its members deal with the accompanying changes, he says.

There is some concern that consumers with CDHPs might not fully realize what they've signed up for, notes **Larry Connell,** FHFMA, CHFP, director of patient financial services at Swedish Covenant Hospital in Chicago.

"You really do have a high deductible, and you have to have money in these accounts [to cover services]," he says. "If you start a plan in January that has a deductible of $5,000, and you have a large service in February, what happens to the claim if you only have $100 in the account? Insurance doesn't kick in until you've met the deductible, so if the bill is below $5,000 you owe the whole amount."

Similarly, it may not have registered with consumers who have these plans that they may not be eligible for the discounts they had in the past, Connell notes. Those who have been accustomed to a copay of $20 may find themselves paying full retail price at the pharmacy, he adds.

To use the plans effectively, people need to be adept at financial planning, he says. "Those with large families who have trouble allocating money will not do well."

If there is not much money in the account, Connell says, people may postpone a minor procedure or a preventive service, such as a mammogram, until the fund is properly funded. Or they may want to save the funds for use after retirement, or in case they need major surgery down the road, he says.

Even if there is plenty of money in the account, Connell points out, there is nothing requiring the holder to use it to pay the physician or hospital.

One insurer Connell spoke with, he adds, said that the insurance cards for his company's high-deductible plan will not display that information.

"[Access staff] will still go through the verification process if they call about the person's benefits," Connell says. "They might think somebody has insurance when they really don't."

A survey by Swedish Covenant of its major payers indicates that they will require the usual pre-verification procedures for the CDHPs. But while his facility's access employees do ask about deductible amounts, others may not, Connell adds. "If it's a minor procedure or an MRI [magnetic resonance imaging], the hospital may go through all the precerts thinking we might get paid, but we're not.

"We had a patient who presented one of these [cards] to us, and there was not a dime in the account," he says. "We billed them — it was about $4,000 — and the account went to collections."

For the past couple of years, notes **Barry Bierman,** executive director for business development for AHC Inc., a Charlotte, NC-based health care receivables management firm, he has emphasized to clients the importance of operating a hospital more like a business.

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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).

That message is underscored in regard to the handling of CDHPs and health savings accounts (HSAs), he says, adding that he has heard from hospital clients about "myriad different experiences" in which such accounts are mishandled.

Those include things like a registrar saying, "We don't need your VISA card right now — we'll bill your insurance and then bill you for any self-pay balance," without realizing the patient was not offering a regular credit card, Bierman adds.

"There is a lot of misinformation out there," he notes. "A lot of providers do not know about all the changes."

If a patient comes in with, say, a Blue Cross-administered HSA and wants to use it to pay for a procedure, the registrar not only needs to verify the balance in that account and charge the HSA VISA accordingly, Bierman points out. The employee then must verify with the insurance company that any remaining balance on the hospital bill is covered, he adds, and determine if it is covered at 100% or 80%, or if the patient is still responsible for an additional copay or deductible.

Detailed questions and proper documentation, Bierman emphasizes, will help protect the hospital's interests down the road.

Identity theft growing concern

With any customer, access staff should ask to see a picture ID, he says, and with the proliferation of high-deductible health plans there is even more justification for stressing that step.

"[Customers] are now coming in with HSA credit cards, into which [in 2006] they're allowed to put up to $2,700 per person, which must be used for medical expenses," Bierman notes. "But what if a person presents that card and it doesn't really belong to him, and the insurance company discovers that it was not the [proper card holder] but some unknown person who was treated? It can deny payment and the hospital can end up with a large self-pay balance.

"There is a lot of identity theft right now," he adds. "A patient could be using a friend or family member's card, and could easily grab from

Price checks part of new consumer landscape

What should access role be?

A major consideration with the increase in consumer-driven health plans is that patients are likely to want to know more about what they now are paying for, suggests **Gillian Cappiello,** CHAM, senior director for access services and chief privacy officer at Swedish Covenant Hospital in Chicago.

That newfound quest for information, Cappiello predicts, will lead to more questions and phone calls directed to access staff, and perhaps some inclination on the part of patients to price-shop and negotiate fees.

While inquiries about pricing flexibility typically are transferred to the chief financial officer or the director of finance, she says, Cappiello questions whether access employees might need to receive training in that regard.

"Are we going to need to empower [staff] to provide the answer if people call to inquire about the cost of a CAT scan? Will they have the bottom line they can go to if somebody says, 'I can get the CAT scan for this amount down the street.' What, if any, flexibility will front-end staff have to say yes or no?"

At minimum, she says, it's key that frontline staff don't just transfer such calls to the finance department heads, but rather communicate back to their supervisors and managers what kinds of questions are coming in

In addition, Cappiello notes, staff will face new challenges in determining and sharing with patients the details associated with meeting the various requirements of consumer-driven health plans (CDHPs).

With these eventualities in mind, she says, Swedish Covenant will create new dialogue — depending on what patients are asking — as part of the scripting program already in place at the hospital.

"The purpose is not to tell people exactly what they should be saying; but the idea is that the message should be consistent," she says. "It's important that [staff responses] essentially have the same content, so we don't have confusion of, 'This person told me this and someone else said this.'"

Having a key phrase ready also "allows a little time to think about what you want to say next," Cappiello notes.

Among other things, she says, scripting will be helpful in "making sure people understand that in some cases a [CDHP] is not insurance — or maybe it is, but the deductible is very high." ■

another person's deductible."

While Swedish Covenant has had relatively few customers with these "combination" plans so far, the hospital is seeing many more insurance plans with higher deductibles, notes **Gillian Cappiello,** CHAM, senior director for access services and chief privacy officer. "So a lot of services essentially are going to be self-pay.

"From a billing perspective, high deductibles are not good," she says. "You have to collect more from the patient, and it costs more money to collect from patients."

CDHPs put providers at risk, adds Connell, because of the potential for more bad debt as consumers fail to pay their share of the costs.

"Bad debt is a challenge," agrees Gundling. As a way of mitigating that risk, he emphasizes the importance of letting patients know up front, "not 30 days later," what their out-of-pocket costs now will be.

Attracting price-sensitive patients

Even more so than before, access departments need a system for communicating patients' responsibilities, Gundling says, and a way to collect that amount or arrange payment terms. With consumers becoming more price-sensitive, he adds, "maybe there will be more one-on-one negotiations."

Gundling says he envisions conversations in which a customer says, "I need surgery. What are your fees?" Hospitals should be prepared to give a good estimate, he adds, perhaps giving the price for a routine procedure without complications.

While it's feasible that consumers "might call around and see where it's most prudent" to have a certain procedure, Connell notes, "the problem is that each facility might quote the service differently."

The price given for a CAT (computerized axial tomography) scan, for example, might or might not include the cost of the dye needed for the procedure, or the radiologist's fee, he adds. "When you call for a quote, typically the hospital cannot quote for the physician."

"Scripting" — encouraging employees to use "key phrases at key times" in communicating with patients — has been an effective tool at Swedish Covenant for several years, notes Cappiello, and will be an important part of handling the challenges posed by CDHPs. **(See related story, p. 75.)**

With the advent of health plans that assign more financial responsibility to consumers will come patients who are "a bit more demanding" of time and attention, Cappiello predicts. "They won't want to feel they're on an assembly line."

To attract customers who are comparison-shopping, Gundling says, hospitals may be compelled to promote both pricing and quality data in a much bigger way. Meanwhile, web sites such as Hospital Compare (www.hospitalcompare.hhs.gov) allow consumers to look at how hospitals measure up to an array of different standards for measuring quality.

As those types of tools become available, it will be incumbent upon hospitals to follow best practices, he suggests. "Before, the physician was the main consumer. Now it's the patient." ■

Nurses are the difference in Vanderbilt POS success

Administration commitment strong

Nursing accountability and a strong financial commitment from hospital administration are fueling a successful point-of-service (POS) collections program in the pediatric and adult emergency departments (EDs) at Vanderbilt University Medical Center.

The EDs went from having no POS collections effort at all to taking in just under $20,000 in March 2004, the first month of the program, says **Tina Williams,** CPC, manager of admitting and emergency registration for Vanderbilt Children's Hospital.

By March 2006, she adds, POS collections for both EDs totaled almost $87,000. **(See graphs, p. next page.)**

Underlining the initiative is "a new spin" on automating the old grease board-style ED board and integrating it into the hospital-wide electronic bed board, Williams notes.

"The system automatically lets the nurse know if a patient needs to come to the discharge station," she says. "Then the database can run reports telling us which nurse that patient 'belongs to,' so we can go directly to the source if someone is not doing her part in bringing patients out."

When registrars click on the white board, indicating that a patient needs to come by the dis-

charge station, Williams explains, the database is prompted to issue a report to that effect. A report from the discharge station database shows whether or not the person did, in fact, come by the station, she adds.

The system is color-coded "just like a stoplight," Williams says, with the colors red, yellow, and green indicating the status of an account.

Beginning at the point the patient presents at the ED, she explains, the process works as follows:

"When our registration greeter does a quick registration, the system pops the patient's name on the white board, which can be viewed at every computer in the ED," Williams says. The triage nurse sees the name and chief complaint, she notes, and can decide, for example, "Am I going to take the person with chest pain or the one with abdominal pain?"

Staff in front or back, including ED physicians, can, with a touch, check the board to see the number of people in the waiting room and their chief complaint, Williams says.

Meanwhile, physicians in the ED's fast-track area can see what's going on, she adds, and may direct staff to pull a particular patient for care in that less acute setting.

Another click moves the person into the treatment area, Williams says. Once the "update registrar" there takes ownership of the patient, that employee goes into the white board and changes the color of that field to yellow, which indicates that someone is working with the patient.

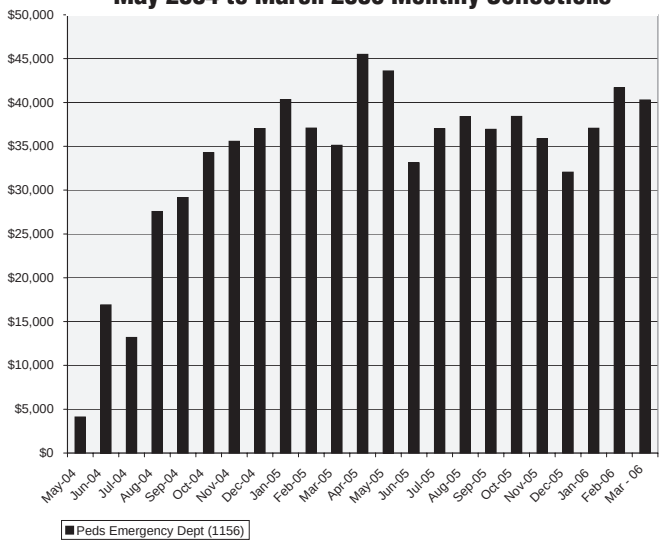
"When the registrar verifies the insurance and knows what the copay is, that person changes the color to red and puts the amount due in the comment field," she says.

At that point, anybody in registration can move the keyboard mouse over to the column, see the status of the account, she adds, and say, "You have a $100 co-pay due. How would you like to handle that?"

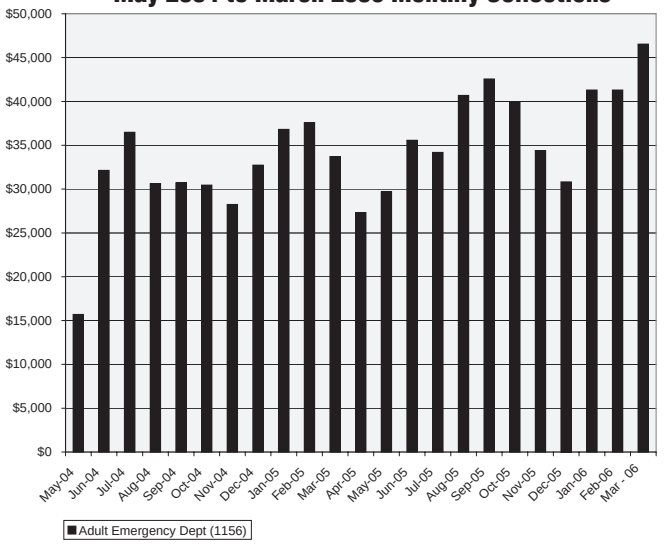
If the person doesn't have a copay due, the registrar changes the field to green, which tells the nurse the patient doesn't need to come to the discharge station at all.

"Part of the discharge station function is to review the registration in real-time," Williams points out. "If there are any questions — say, the update registrar didn't get an emergency contact outside the home — the registrar at the discharge station will click the field to yellow, and put in a comment saying to get the contact.

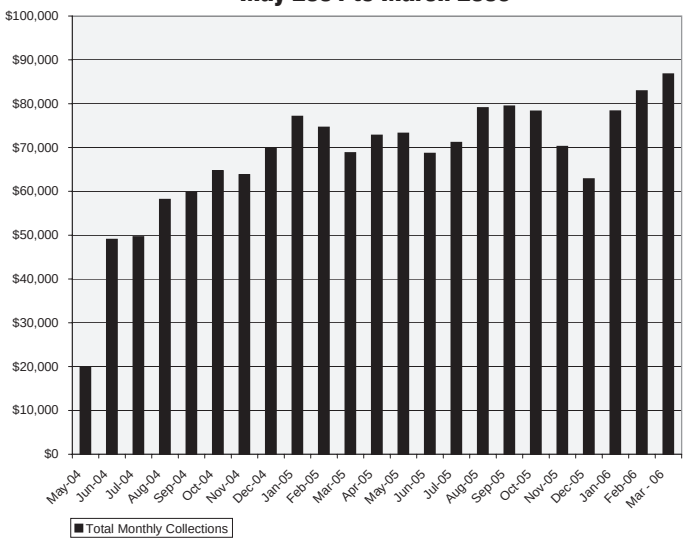
Peds ED
May 2004 to March 2006 Monthly Collections



VUH Adult ED
May 2004 to March 2006 Monthly Collections



Total VUH & VCH ED Monthly Collections
May 2004 to March 2006



Source: Vanderbilt University Medical Center

"Anybody in registration knows to 'mouse over' and see what is needed, so whoever is there will get that information and text it in."

Electronic white board speeds process

The speed and ease with which the electronic white board operates facilitates the entire process, Williams notes. "The last thing we want to do is hold up the patient any longer than we have to."

Nurses escort patients who are in "red" or "yellow" status to the discharge station, she says, and place a label on a clipboard indicating they have done so. If the station happens to be unmanned, Williams adds, the label serves as documentation.

"We don't have [staffing] depth on the discharge station — just enough staff to cover it during most of the peak hours," she notes. While all registrars are trained to handle that function as needed, Williams says, "we may miss one. The labels ensure that nurses still get credit for bringing the patient out."

Discharge staff manually note in the database if a collection opportunity was missed due to the station being unmanned, she says.

Monthly reports are sent to nursing administration giving the overall percentage of patients from each ED who are brought by the discharge station, she adds, "so they know to keep talking to the charge nurse about how important it is."

"We're still not at 100%," Williams says. "We were at 40% when we started measuring this, and now we are over 80% on most days; it depends on who is working. Some nurses are great and understand the need for buy-in, and others don't really think it's their job."

The only time these efforts didn't seem to make a difference was in November and December, when holiday demands had "people hanging on to every dime," Williams says.

"If patients are not able to pay, we give them a payment coupon card with a number to call, and we enter into the system whatever arrangements they've made," she says. "We put a note that, for example, the patient said [he or she] will pay on Dec. 12, and the person doesn't need to wait on a statement."

This step also ensures that, if the patient does follow through with the arranged payment, ED registrars get credit for the collection, Williams points out. "The business office knows to post the code [on the coupon] to give us credit, even though we didn't collect at the time of service."

Before instituting its program in 2004, Vanderbilt in Nashville was the only hospital in the area not collecting in the ED, she says. "We got a lot of people who wouldn't go to [a facility in] their network because there they would have to have a copay."

"It was a well-known fact that you could go to Vanderbilt without an out-of-pocket [payment] at the time of service," Williams recalls.

In preparation for the new policy, the hospital put out news releases "to prepare people for the culture shock," she says. "We tried to be conscious of the fact that it was a big change."

Based on visits that hospital staff made two years ago to other facilities in the area, Vanderbilt has been "much more successful as far as dollars collected" than its counterparts with similar patient volumes, Williams says.

"I've had people from other states call me because they were not able to collect the dollars that we are collecting," she says. "From what I can tell, it's mostly the nurses' buy-in — because the administration holds them accountable — that makes the difference.

"I want to give the nurses a lot of credit," Williams says. "At other facilities that didn't have [nurse buy-in]; they didn't really have a clear way of getting the patient to the discharge station.

"We can collect if we talk to [customers]," she notes, "but if we don't talk to them, we can't get anything."

Pediatric collections higher

In the business plan they put together for Vanderbilt Medical Center administration, hospital department heads and outside consultants predicted that the adult ED would collect more than its pediatric counterpart, Williams says.

The rationale, she adds, was that most children are either insured through their parents or covered by TennCare, the state's Medicaid program, which does not require a copay.

However, on the adult side, there are quite a few TennCare patients who do have copays, Williams says.

Surprisingly, though, "for the most part, we're collecting more at the children's ED," she notes. "We've never really figured out the reasons behind that, but it was a nice surprise to be that

successful in the children's ED."

The collections effort required extra employees, Williams notes. "At the beginning, we added a total of seven people for both EDs, which was 6.3 full-time equivalents [FTEs] since our staff work 36-hour shifts.

"Originally we just manned the discharge station during peak hours, but now we're up to 10 FTEs," she says. "We have expanded our hours over the two years, but we still don't man it 24/7, although we're close to that."

While the intent of the program is to collect the amount due at the time of service, it also is to provide assistance when needed, Williams says. "Our discharge stations are set up so [the function is] more like a patient advocate."

If a person comes to the ED for treatment and needs follow-up orthopedic care, but is out of network, she adds, "We tell the patient to please contact his primary care physician and [ask for a referral] to an orthopedic specialist in that network. Why send them back within our system if they'll have to spend twice as much?"

If the patient is self-pay, Williams says, "we have handouts listing clinics within the area that offer preventive care and see people on a sliding [fee] scale. We also initiate a Tennessee Medicaid application for state residents who are uninsured, and give them an instruction sheet on how to complete the process."

The hospital's case managers assist with patients who need follow-up care within the Vanderbilt system, she says.

While she thought patient satisfaction surveys would suffer with the advent of ED collections, the latest scores are in the 99th percentile, she says. "They're better than they've ever been. It's not as big of a shock anymore."

The possibility exists for more dramatic increases in collections, Williams suggests. "We have gone from collecting $20,000 a month to upwards of $80,000, and we still have days when only 50% of patients who owe co-pays are brought to the discharge station."

Although there are many days when that figure is 80% or even 90%, these outliers bring the average down to "about 60% or 65%," she says.

"As we tighten our process," Williams adds, "there's the potential to get much more of this low-hanging fruit."

[Editor's note: Tina Williams can be reached at tina.williams@vanderbilt.edu.] ■

'Multivariable testing' aids process improvement

Statistical analysis is key

Results are "preliminary but promising" with the use of something called "multivariable testing" (MVT) to identify and implement ways to improve patient satisfaction at Blount Memorial Hospital, says **Richard Hall,** RN, MBA, chief nurse executive and assistant administrator.

Using MVT, Hall explains, the 304-bed hospital is simultaneously testing a number of improvement ideas, individually and in combination, to determine which activities result in improvement, which don't have any effect, and which actually have a negative impact.

Blount Memorial in Maryville, TN, is working with QualPro, the Knoxville, TN-based company that developed the MVT process, on a six-month project focusing on its emergency department (ED) and operating rooms.

One test involves next-day follow-up calls to patients who have been treated in the ED, Hall says. "We do call-backs anyway to talk about whether they have any questions or if Johnny still has a fever."

Now the staff member making those calls also asks about pain management and about the customer's overall satisfaction with the ED experience, as well as whether he or she would recommend the facility, he adds.

Compared to traditional ways of measuring customer satisfaction, Hall says, "we have a month's worth [of data] in one day. We see 120 to 140 people a day in the ED, so that makes it statistically significant for us."

As expected, he notes, two things the hospital already was doing were validated as improving throughput and patient satisfaction. "One was having the ED physicians write admission orders, based on signs and symptoms, rather than waiting for the specialist, and the other is that we have an admissions holding area for patients we're not sure are going to be admitted."

In another instance, the variable being tested was successful in two ways, one of which was totally unexpected, Hall says.

The hospital developed scripts for ED personnel to use in explaining to patients the reasons for their wait times, and to lay out expectations for what the ED visit would entail, such as "seeing

the physician, asking questions, having tests run," he notes.

The idea was to enlighten people as to why they were waiting, but in the process of doing that, staff became more focused on the need to keep people from having to wait, Hall says. As a result, he adds, "they got more creative in getting people back to the treatment room," which resulted in improved throughput times.

"Without this system," he adds, "we wouldn't have discovered that. You make changes all the time, but you don't always know if they will result in improvement."

Historically, process improvement efforts involved "having a consultant come in, say, 'This is the problem,' and then, 'Here is what has worked in other hospitals — we think it will work here,'" recalls **Samuel Evans,** MD, the hospital's medical director and administrator of the OR piece of the Blount Memorial project.

"You end up looking at ideas, saying, 'Try this,' and if that doesn't work, 'Try something else,' and eventually you get frustrated and quit."

By testing several ideas at the same time, he says, "you have proof of what is helping and what's not. The technique used is very intensive on the statistical side."

QualPro uses an MVT categorization process, a company news release states, "to narrow test ideas to only those that are practical (easy and safe to test and implement with current resources), fast (quick to implement with current resources), and cost-free (no increase in operating cost or capital)."

Experience has shown, Evans notes, "that about 23% [of test ideas] will help, about the same percentage will hurt, and the rest of the variables will do nothing. There is no way to predict which will fall into which category."

To prepare for the OR portion of the project, he says, sessions were held with surgeons, anesthesiologists, and OR staff. "We asked, 'What are your problems and what do you think will help?' We took all the ideas everybody had and analyzed them and came up with 23 different variables to test.

"One day we test two or three variables, the next day we change and do two more, and we do that for 30 days," Evans continues. "Then we collect all the data and do a statistical analysis and say, 'It appears this variable is helping, this one is also helping, this is not helping at all and is actually hurting.'"

At that point, some of the variables are eliminated, and there is another series of tests on the smaller group, he adds, "and we see what helps."

One of the tests involved notifying surgeons the day before to verify scheduled procedures, Evans says. As a result of this advance check, he notes, "sometimes [the surgeon] decides to change the plan, or discovers there is an error in how it was recorded."

Catching such glitches a day in advance, he notes, prevents last-minute cancellations that irritate patients and family members, delay turnaround time, and cost money "because the room is set up for one patient and you're changing to another."

"One of the things we're doing to improve customer satisfaction is to be sure to communicate with family members so they have a better indication of when to be here, what time the surgery will begin, and when it will be over," Evans says. "We look for ways to stimulate staff so they know to communicate that information at certain points."

Hall points out that "while the literature is full of good ideas" for process improvement, the difficulty lies in identifying those that can be implemented and will actually result in improvement for the patient.

"We've got to make our resources count to the fullest for our patients and maximize all opportunities to do so," he adds. "This system helps us know in advance whether long-term implementation of those resources will make sense." ■

AZ 'Health-*e* Connection' aims to be national model

Task force develops 'road map'

A person is far from home, driving on an interstate highway, passing through a rural area and, because of an accident or a sudden illness, is taken for treatment to the emergency department (ED) of a nearby hospital. Even if the individual is conscious and able to communicate, those providing care are limited by their inability to access the person's health care records.

"Wouldn't it be great if there were standard procedures for getting that information?" says **Julie Johnson,** CHAM, director of revenue cycle management and HIPAA privacy officer at Mt.

Graham Medical Center in Safford, AZ.

"If the person is able to communicate, you can get a list of the medications they're on, but if not, the physicians have to use their best judgment," she adds. "What if the person needed blood, and the blood type was right there?"

Being able to have that information available quickly and efficiently when such occasions arise is the goal of a program called Health-*e* Connection, established by Arizona Gov. Janet Napolitano, who has said she wants her state to be the national model for electronic connectivity of health care records.

The plan is to create the infrastructure necessary to achieve 100% electronic health data interchange between payers, health care providers, consumers of health care, researchers, and government agencies, Johnson says. "It's all about standardization."

Going electronic

"We've all been directed to have electronic health records by 2010," she points out. "It will take every part of the hospital, including access."

Even the insurance company knowing right away that a covered person is in for services would help treatment be given more efficiently, Johnson notes. "Who's to say the trigger [for the data exchange] is not through access notifying the payer? Perhaps that will be how it's generated. Or maybe it will be through accessing a clinical database."

While there are a few other regions in the country with well-developed systems for electronic connectivity of health care information, Arizona's project is one of the first statewide efforts, says **Kristen Rosati,** JD, chairperson of the Privacy and Security Task Group.

"I think Arizona is a real model — No. 1 because we have created a collaborative atmosphere," adds Rosati, an attorney with the Phoenix-based firm Coppersmith Gordon Schermer Owens & Nelson, PLC. "That is one of the reasons we have been able to do this so quickly."

Napolitano launched the project in October 2005 with a "call to action" meeting that drew some 200 people, including physicians, hospital CEOs and chief financial officers, health care lawyers and vendors, among others.

As a result of their efforts, the Arizona Health-*e* Connection *Roadmap* — a document which focuses on the "what, when, why, and who" necessary to create the desired infrastructure — was delivered to the governor this April.

"Everyone really felt like they had a place at the table, including consumers," Rosati says. "The governor convened a steering committee, which was the decision-making body, and then the steering committee convened the work groups."

In addition to the privacy and security group, there are work groups covering financial and technical concerns.

"The road map sets forth the sort of projects we want to do," Rosati adds. "Over the next year, we will look in more detail at how to make sure privacy and security of health information is protected as we decide which of these options will be implemented."

Johnson, who learned of the initiative through a call for participation from several state health care organizations, was present at the initial meeting, she says, and ultimately became part of one of the privacy and security task group.

What's private in an e-health info exchange?

As part of that group, she brainstormed with other members on potential legal barriers to the development of the proposed e-health information exchange, and how best to safeguard the confidentiality of the data, Johnson says.

Some of the challenges addressed, she adds, included the following.

• How will the e-health information exchange address consumers' control over their own health information?

On one hand, consumers legitimately want control over their health information and want the right to choose whether to participate in a health information exchange. On the other hand, seeking consumer consent could mean that a person might need the benefits of the system — as in the car accident mentioned above — before he or she has the opportunity to opt in or out of the system.

Additionally, seeking consent would not only be an expensive and administratively difficult task, but also would diminish the effectiveness of the information exchange in addressing public concerns, such as using the information for bioterrorism surveillance.

• How will the e-health information exchange handle "special" health information that has greater confidentiality protection?

This might include records related to a patient's HIV status, for example, or the notes of a session with a psychotherapist, Johnson points out.

Other types of health information that have greater confidentiality protection than that provided by the Health Insurance Portability and Accountability Act (HIPAA), which forms the federal "floor" of protection, are such areas as genetic testing, mental health, and alcohol and substance abuse treatment.

Some of the options identified for handling such information in the exchange are: excluding all data that require this special protection; including some sensitive information but excluding that which has the greatest restrictions on use and disclosure; including the information, but restricting the use of *all* information in the exchange to comply with the most restrictive laws; determining a way to flag information that requires more confidentiality protection; or asking the state legislature to amend laws to facilitate the e-health information exchange.

"Across the country, states have more restrictive laws," Rosati notes. "HIPAA forms the floor, but we have to make sure we are complying with state law. It's tricky, because as we're doing the exchange, we need to have a way to protect more sensitive health information. A person may go into a clinic for genetic testing, but not want that in the medical record.

"There is a lot of concern that if such information lands in the wrong lap, there might be discrimination against [those to whom it relates]," she says. "There is some tricky technology [that will] shield that information from the data exchange. We are working closely with people, identifying the technology we are going to use."

• How will the e-health information exchange handle minors' health information?

Minors have the right to consent to certain types of health care in Arizona, such as treatment for sexually transmitted diseases, HIV testing, and alcohol and drug abuse treatment, as well as prenatal and other reproductive care. If they are emancipated, have been married, are homeless, or are in the military, minors have the right to consent to *all* health care.

However, the roadmap points out, they also have the right to control the information related to that care and must authorize disclosure of that information to their parents or guardians. The challenge for the electronic information exchange then becomes determining how to meet the participants' legal obligations to protect minors' rights in that area.

To meet that challenge, the task force will consider such options as implementing a mechanism for providers to flag information related to health care for which a minor has given consent but which also requires authorization for release of that information to parents. Another option would be excluding minors' health information from the system if it relates to health care for which the minor has the right to consent.

The latter may have negative consequences if the excluded information is significant to other treatment provided to the minor, the roadmap states.

Another option is that the e-health information exchange could request the Arizona legislature to pass a law granting parents and guardians the right to see their children's health information, perhaps with exceptions to protect minors in cases of abuse or other circumstances.

The concern with that route is that it could discourage minors from obtaining prenatal or reproductive care or treatment for sexually transmitted diseases.

• Who will have access to the e-health information in the exchange and for what purpose?

It must be determined, for example, whether health plans and employer group health plans will have access to information in a patient health summary.

The most important message for access professionals and other health care providers, says Rosati, is to participate in the development of electronic health care exchanges in their own regions and states.

"The more that hospitals and their representatives are involved in the creation of these systems," she adds, "the more they will reflect the needs of the hospital." ■

Billing transient patients challenge for rural facility

Staff take extra ID steps

Access staff at Memorial Hospital, a small, rural facility, face more than the usual challenge in ensuring that there's enough information to successfully bill patients, says **Melissa Eberspacher,** business office director.

"It's always difficult to track down patients

Specialty hospitals not exempt from EMTALA transfer rules

Provision clarified in new regs

Specialty hospitals that do not have emergency departments (EDs) are still subject to the Emergency Medical Treatment and Labor Act (EMTALA) rules on acceptance of patients for transfer, cautions **Stephen A. Frew,** JD, a risk management specialist and web site publisher (www.medlaw.com).

That provision is not a recent change in policy, but is made "absolutely clear" in proposed new regulations from the Centers for Medicare and Medicaid Services (CMS), Frew recently pointed out.

"CMS has always taken this position, and has cited specialty hospitals for failure to take transfers," he says. "The new regulations follow a recommendation based on reports that specialty hospitals have turned down patients on the theory that because they do not have an ED they are exempt from EMTALA."

The new language in 42 CFR 489.24(f) will be:

"Any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if it has the capacity to treat the individual."

The language does not mandate that specialty hospitals add an ED, Frew says, but emphasizes that private specialty hospitals of any type may not evade the obligation to accept transfers required by EMTALA.

He predicts that more psychiatric, obstetrics, orthopedic, and cardiac hospitals will be cited by CMS as frustrated general hospitals begin reporting turn-downs of ED and inpatient transfers of unstable patients in need of a higher level of care.

"I am aware of many locations where this battle has been building toward explosion, and 'fair notice' has now been given," Frew adds. "Transfer requests and reports of denials are going to push this issue into open warfare if specialty hospitals don't heed the warning." ■

who don't provide a lot of information, especially travelers who are just passing through the area via the nearby interstate," Eberspacher adds.

With those potential "no-pay folks," as well as with area residents who know they can't be turned away from the hospital clinic, staff at Memorial in Seward, NE, take extra care when gathering data, she says.

"We have tried to educate nursing staff to ask [transient patients] to stop by the billing office prior to leaving the facility," Eberspacher notes. "Then collection staff will re-ask questions, or get them to repeat things. They do a search program to verify the person's Social Security number, telephone number, and last known address.

"We also urge the business office staff and the nurse to get some form of identification," she adds. "If the person is uninsured, he or she may not have an insurance card."

Eberspacher says she is pushing for the establishment of policies and procedures for requesting some sort of estimated payment from the patient at the time of service.

At the clinic, she says, registration staff go over the patients' information with them, and say things like, "Can we take another number for you?" or "It shows in my notes that you've had some visits to us before, and the letters we sent to this address came back. Is there another place we can contact you?"

Meanwhile, Eberspacher adds, "we try to ask a lot of questions and let people know we will be looking for them for payment on the account."

[Editor's note: Melissa Eberspacher can be reached by email at mhcsmeberspacher@alltel.net.] ■

COMING IN FUTURE MONTHS

- Disaster victim locators
- Vanderbilt's 'Team Triage'
- Identifying self-pay patients
- 'Turnstile' ED program
- Inpatient preservice collection

NEWS BRIEFS

Fewer workers enroll in employer health plans

Three million fewer workers elected to enroll in their employer's health insurance plan between 1998 and 2003, a period when the cost of individual premiums increased 42%, according to a recent study by the Robert Wood Johnson Foundation (RWJF).

More than half of all adults without health insurance cite the high cost of coverage as the reason, the study notes.

"This report should be as alarming to Congress as it is to the American people, because employer-sponsored health insurance is the backbone of America's health care system," said Risa Lavisso-Mourey, MD, RWFJ president and CEO. "If trends continue, this could dramatically increase the number of working but uninsured people in this nation." ▼

IRS sends questions to tax-exempt hospitals

The Internal Revenue Service (IRS) has begun sending tax-exempt hospitals a detailed inquiry known as a compliance check questionnaire seeking information about their operations.

The questionnaire includes sections on uncompensated care policies, community care programs, compensation practices, and board organization. The compliance check is not an audit, but an examination of the tax-exempt entity's compliance with rules and regulations. However, the IRS has noted that some examinations have resulted in audits.

More information is available at www.aha.org/aha/key_issues. ■

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