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Wake Forest initiative hastens ID of patients mislabeled 'self-pay'

Six Sigma project leads to real-time audits, enhanced communication

A Six Sigma project at Wake Forest University Baptist Medical Center in Winston-Salem, NC, has significantly quickened the identification of patients who initially are listed as self-pay but found to have insurance after being admitted.

The effort began because financial counselors working on obtaining information and making payment arrangements for self-pay accounts were finding that many of those patients actually had insurance, explains **Margaret Currie-Coyoy**, Medicaid program specialist.

"The focus of these financial counselors, who refer accounts to myself as a Medicaid [specialist] and other individuals who work with state agencies, is on collections," she notes. "We wanted that focus to be on true self-pay patients, so we decided to see if we could reduce the number of accounts they were receiving for which insurance could have been gotten sooner."

Because they put an extra focus on collections, Currie-Coyoy adds, these financial counselors are called resource recovery specialists.

Verification and quality services (VAQS) staff members, meanwhile, were noticing that these accounts — typically identified a day or so after admission as having insurance — were having to be appealed because of the miscommunication, she says.

"Medicaid of Virginia, for example, requires a 24-hour notice for admission," adds **Keith Weatherman,** CAM, MHA, associate director, patient financial services. "If it looked like a patient came through the emergency department [ED] and was admitted, and [staff] had not picked up on Medicaid of Virginia [as the insurer], they would deny payment."

The Wake Forest medical center gets a large number of referrals from other facilities, he notes, and some of those patients may go through the ED before being taken directly to a bed, but are not actually registered in the ED. Many of those patients, Weatherman adds, do bypass admissions.

The project team — led by Currie-Coyoy as part of the requirements for obtaining her Six Sigma green belt certification — first looked at the number of inpatient accounts miscoded as "personal pay" (the "defects," using Six Sigma terminology) and the admission source, she explains. "Since the greater number of defects occurred in the ED — approximately 50% — the project was scoped to focus on the ED registration process."

The team then defined the project's primary metric as the number of inpatient accounts miscoded as personal pay in the ED, Currie-Coyoy says. **(See graphic, p. 87.)**

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Editorial Questions

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"We worked with data from June 2005 through August 2005, which indicated that of the 683 inpatients registered as personal pay in the ED during that period, 185, or 27%, actually had insurance," she adds.

Meanwhile, the VAQS staff had to appeal $40,000 in charges denied by insurance companies because of missed pre-notification, she says.

Weatherman points out that the problem being addressed involved "very sick patients coming through the ED" and was more a procedural issue rather than people not doing what they should be doing.

"Six Sigma is about constantly seeking the cause [of a problem], with the assumption that people are trying to do their job the best they can, and seeing if anything can be done to improve the situation," Currie-Coyoy says. "Of course, people will not always have their insurance card with them and family members may arrive after the patient has left the ED [and been admitted].

"We analyzed that 27% with the Six Sigma tools and tried to reduce the number of defects as much as possible, but allowed for circumstances outside our control," she adds. "We just wanted to reduce it. Sometimes it takes repeated attempts."

To come up with the project's target, Currie-Coyoy explains, the team looked at the 27% average of misidentified self-pay patients, and then at the one week during that period when it was the lowest (19%).

"We take the difference between the baseline and the best-case data, and try to improve the baseline by at least 70%," she says. "So we at least wanted to go from 27% down to 21%. The team also wanted to ensure that no ED inpatient accounts miscoded as personal pay resulted in denial for missed pre-notification, Currie-Coyoy adds.

Potential improvements ID'd

Through the use of Six Sigma's DMAIC (define, measure, analyze, improve, control) tools, she says, the team recognized three potential improvements for the ED registration process regarding inpatient accounts miscoded as personal pay: the need to standardize registration procedures for patients who present to the ED without insurance cards, the need for real-time auditing, and the need for a communication log for ED registrars and nurses.

Members estimated that improvement would result in a saving of labor hours for the financial counseling group, Currie-Coyoy says, as well as reducing denials.

"We looked at causes as to why accounts were left as 'self-pay,' such as trauma patients and those with high acuity, and at something getting missed because of high volume during certain shifts," she notes.

The team surveyed admitting representatives regarding what happens if a patient comes in without an insurance card or if pieces of information are missing, she says, and did a closer study with three of the employees.

"We realized that about half the clerks thought they were correct in leaving the designation as 'self-pay' (rather than noting that the insurance information was unverified or incomplete)," Currie-Coyoy says. "We verified with them that we want to leave an 'insurance shell' even if all the information isn't there."

One tenet of Six Sigma is to reduce variation, she points out, which led to another facet of the project. In some cases, Currie-Coyoy says, family members arrive in the ED after a trauma patient or one with high acuity has been taken to the nursing unit, and the employee at the information desk refers them to the patient family coordinator, who is part of the nursing staff.

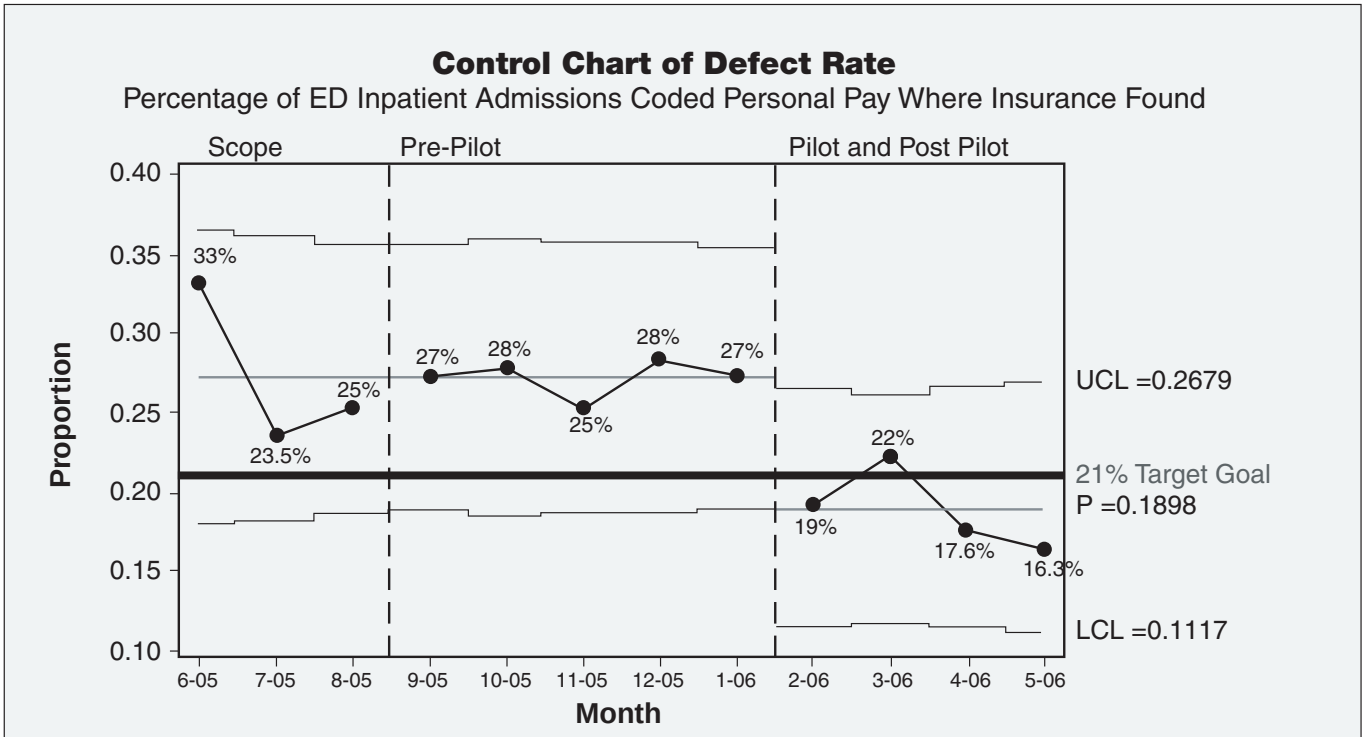
"Generally, the ED [registrar], if she had a registration she was unable to complete, might tell the coordinator, 'If you see this family member, please refer [him or her] to me so I can get more information,'" she says. "So there was [already] a verbal communication in place."

The team, however, recommended creating a log book, with carbon copies, in which the ED registrar could write a memo to the coordinator. In addition to the patient's name and registration number, the memo would include a message noting that the registration was not complete and asking that family members who arrived be directed to a particular registrar to provide assistance.

"Then when the family members arrive, [the coordinator] knows exactly which person to send them to," she says.

In addition to formalizing the verbal communication that was already happening, the new procedure — which provides documentation — gives more impetus for the patient family coordinator to get involved, she adds. "We had the head of nursing sit in on a couple of meetings, and she fully agreed and is backing the effort."

Post Pilot Results: Primary Metric



Source Wake Forest University Baptist Medical Center.

Another team recommendation was to have some real-time audits performed by the ED supervisor during each shift, Currie-Coyoy says, "to see if [registrars] are getting the insurance information, creating the shell, and making sure to get all the demographic information."

While some fairly aggressive auditing was done during the pilot project, which ran from February to April 2006 the effort has since lessened but is still ongoing, she adds.

"The team also recommended that the [registrar] put a note on the account when something is not able to be obtained," she explains. "If, for example, the patient stated, 'I have insurance,' but can't remember the name of the insurer or anything else, the [registrar] could document that."

After spending a couple of months analyzing data, discussing ideas, and getting input from ED registrars, the team began instituting changes, she says. "Immediately, in that month, the defect rate, as an average number, went from 27% to 19%. We continued our pilot, brought in one [recommendation] at a time, and officially ended the pilot in April."

Over that three-month period, the average defect rate was 19.8%, which was still below the target (21%), she adds. "We had our best month ever in May, when the average rate was 16.3%. That brought the average since the changes down to 19%."

In addition, the hospital has not had to appeal any accounts that were denied because they were left personal pay since September 2005, Currie-Coyoy notes. "That means we haven't had any lost or delayed revenue [due to that issue]."

Much of the improvement was because of the enhanced cooperation between ED registrars and the financial counseling group, she says. "It was the whole notion of having the team together and talking — with just that, we started making positive changes. It's really about the communication." **(See related story, this page.)**

While the project has yet to register any gains under the technical definition of "hard savings," there are now three financial counselors working with self-pay patients where before there were four, she adds. "The fourth position is now in limbo. If we are able to free it up, we can give that person other responsibilities."

Not counting that potential elimination of a position, the project resulted in $3,100 in saved labor costs, Currie-Coyoy explains. The reduction from 27% to 19% represents "soft savings," she adds, because as of yet, nothing can be cut from the budget as a result.

Verification system added

In light of the frequency with which patients present without an insurance card or without complete information, she adds, the final team recommendation had to do with implementing a real-time insurance benefit verification system.

The process of bringing that idea to reality was well under way by late June, Weatherman notes, and the new system was expected to be up and running by early August.

The product is "like a template that sits on top of the registration pathway and helps guide the registrar through the process," he says.

Using triggers such as name, date of birth and Social Security number, Weatherman adds, it will be able to verify coverage by Medicaid and a number of other third-party payers without the registrar having to leave the registration screen to pull up an on-line verification web site or call and enter the eligibility information by phone.

The hospital can put some of its own rules into the system, which likely will be able to "pop up and ask questions, like TurboTax," he notes.

The verification system also can check the address given by the patient against a national database of addresses to see if there is a match, Weatherman points out. "We can save a lot of time for people who are currently verifying insurance manually and those worrying about returned mail," he says.

Once the system is in place, Weatherman notes, "we will be looking at [full-time equivalent] savings."

(Editor's note: Margaret Currie-Coyoy can be reached at mcurrie@wfubmc.edu. Keith Weatherman can be reached at kweather@wfubmc.edu.) ■

'Learning Exchange' promotes staff awareness

Employees walk in others' shoes

A Six Sigma project involving four different departments was the impetus for a "Learning Exchange and Appreciation Program" (LEAP) that allows patient financial services

Proposal for learning exchange and appreciation programming

Objectives of LEAP

Patient financial services (PFS) is comprised of 14 departments in multiple locations with numerous employees in various roles and responsibilities from front-end registration to back-end collections.

- LEAP will provide the opportunity for employees from each department to observe, learn, and exchange ideas with employees in other PFS areas.
- LEAP will allow visiting employees to learn about the function and processes of other departments and how their own duties may impact work in other areas.
- LEAP will open lines of communication between fellow PFS employees by providing a space for dialogue and feedback.

Guidelines for LEAP

Each participating PFS department will select and/or nominate departmental *ambassadors* to represent each functioning area of the department. Departments will host 1-2 *visitors* per month. *Visitors* will be greeted by the departmental *ambassador*, introduced to other personnel, and will spend the remainder of the time observing and interacting with the *ambassador*. *Visitors* will stay with the host department for a full eight hours, 1st, 2nd, or 3rd shift (preferably with a meal together).

- *Ambassadors* will present information to *visitors* regarding how their individual job duties contribute to the department and the division. *Ambassadors* will provide examples of job duties and what activities constitute a typical work day. *Visitors* will be free to take notes, ask questions, offer suggestions, and discuss how processes in their own department relate to the host department.
- Host departments can provide literature to *visitors* and/or examples of common materials utilized by employees.
- *Visitors* will be asked to complete a survey fol lowing their observation experience.
- *Ambassadors* will be selected by managers; *visitors* may volunteer and can participate at the discretion of their managers.
- Managers should take into account the willingness and initiative of employees to participate in the program as *ambassadors* and/or *visitors*. Those employees who participate as *ambassadors* and *visitors* will receive formal recognition.

Job Descriptions of Participants

- *Ambassadors* have worked in the department for at least one year. They are willing to represent the department, to teach, and to share many aspects of their job duties with other employees. They will provide a positive atmosphere for learning and exchange as well as demonstrate a welcoming attitude to *visitors*.
- *Ambassadors* will also be responsible for notifying the department when visits are scheduled and who is coming from which area. That way, *ambassadors* can encourage the whole department to be welcoming.
- *Visitors* have worked in the department for at least six months. They express an interest in understanding the processes of other areas and desire interaction on a positive level with employees from other areas.

Training Requirements

- *Ambassadors* will be trained through either written guidelines and expectations or a short training session in which they will be encouraged to communicate positively with visiting employees and given suggestions regarding how time with *visitors* can be best spent. ■

employees at Wake Forest University Baptist Medical Center to "walk in the other person's shoes" and gain a better understanding of the way things are done outside their own work area.

While it's more typical for Six Sigma projects to have participants in one, or maybe two, departments, a recent patient financial services initiative included staff from four, says **Margaret Currie-Coyoy,** Medicaid program specialist, who led the project as part of her requirements for becoming a green belt.

The departments represented were the ED, patient financial resources, admissions, and verification quality services, she adds.

During that experience, "we found there was a need for some awareness of each group's individual process," she notes. "For example, when the financial counseling group received a

defective account from the ED group, they might have questioned why it was done that way."

In the ED, on the other hand, Currie-Coyoy says, "maybe there was not as much awareness of who is receiving those accounts and what they will be needing — that they could benefit from having [an explanatory note] on the account."

As the project progressed, she says, team members made comments such as, "Wouldn't it be great if this person could come and see what I do, sit with me, and see everything I face?"

The discussion that ensued led to having two ED staff members sit with a financial counselor and a Medicaid worker for a couple of hours, Currie-Coyoy continues. "They talked about their roles, their responsibilities, what they did on a daily basis, and how they gathered information."

The latter two employees then took a turn sitting with a registrar in the ED, to get a feel for the different scenarios that arise in that area, she says.

All of the people who participated in the work exchange weren't necessarily on the Six Sigma team that met each week, Currie-Coyoy adds, "but they were willing to participate, were aware of the project, and we got their input."

In March 2006 — about midway through the Six Sigma pilot looking at more quickly identifying patients initially listed as self-pay but later found to have insurance — Currie-Coyoy and the team put together a proposal calling for the creation of LEAP, she says. **(See excerpt p. 89.)**

"Our idea is for everyone to eventually be a part of it," Currie-Coyoy says. "We're all affected by what each department does." ■

THR's on-line training meets consistency goal

Modules are customized, interactive

A customized on-line training program for patient access employees at Arlington-based Texas Health Resources (THR) is improving performance, helping to ensure compliance with policies and procedures, and enhancing proficiency across the 13-hospital system, says **Patti Consolver**, CHAA, CHAM, corporate director of patient access services.

With hospitals scattered throughout the Dallas/Forth Worth metropolitan area in a 100-mile radius, maintaining training consistency was a major challenge, adds Consolver, and it was not deemed cost-effective to dispatch a trainer to all the health system's facilities.

With that in mind, the patient access directors from each facility that make up THR's Patient Access Services Operation and Performance Improvement Council (OPIC) came together in the fall of 2003, training manuals in hand, and identified the need for a learning model that would combine web-based and instructor-led training, she says. **(See related story, p. 91.)**

A proposal to develop eight — since increased to 10 — on-line training modules was approved by THR corporate finance, Consolver says, with the content to be as follows:

- patient access overview;
- managed care and governmental programs;
- customer service;
- the art of collections;
- regulatory requirements;
- patient access forms;
- importance of the employer table;
- financial policy.

After considering several vendors, the group selected College Station, TX-based K2Share. Two training modules were completed in the winter of 2004, and all nine (including the additional reimbursement module) were in use in 2005.

To create the modules, Consolver explains, "I put together the material, in a PowerPoint slide or policy format, and [the vendor] pulls out the information and places it in an interactive module, which has vocals and action and holds the user's attention."

There was a photo shoot for each module using THR staff, she adds, so the people shown in the presentations are familiar to users.

"There were 25 or 30 people — two or three from each of the various entities — and it took about four hours to take photos to use for screen shots," Consolver says. "Those shots were built into the modules. We had the option of going with stock photos, but we thought [using staff members] would make it more user-friendly."

Modules are updated regularly — with policy changes, for example — to keep them up to date, Consolver says.

"The best piece from a corporate perspective," she adds, "is that we are able to track results. If someone from compliance or finance comes in and says, 'Are [access employees] familiar with

this or that policy?' I can pull up something called a 'registrar's report,' which is a student listing that includes everyone who's passed or failed the tests. I can say, 'Yes, they've passed the test on that material, and here's the average score.'"

The information is generated into the reporting feature in real-time, she notes.

Before receiving their annual evaluation or merit pay increase, access staff must watch the modules again and retake the tests as a re-evaluation of their skills and knowledge, she says. "They can take the tests twice, but if they fail both times, they are required to schedule one-on-one remedial training with a supervisor."

Staff feedback sought

After implementation of the first three modules, management decided to gather input from staff on the program's usability, Consolver notes. "We distributed a survey to the users and made improvements based on their feedback."

While employees gave two of those initial modules — patient access overview and customer service — good reviews, they indicated that the one covering managed care and governmental programs needed some fine-tuning, she says.

"There were 53 slides, and it took almost an hour and a half to go through it," Consolver says. "We learned that was too much to take at one time, so we put governmental reimbursement in one module, and did managed care separately."

Staff have 30 days to do a module, Consolver says, and may go back and take it again, even if they pass the test.

In addition to promoting patient access training consistency across the system, she notes, the modules have enabled managers to pinpoint areas where employees need extra help and focus on those topics in an updated version.

"I met with the compliance auditor probably six weeks ago, and she had seen a significant increase in [staff] compliance regarding admitting forms," Consolver adds. "Before they were not completing them accurately, sometimes having the spouse sign instead of the patient, but the audits are getting better."

Consolver received a great deal of input from the chief compliance officer and the vice president of finance on that issue, she says, and redesigned the module accordingly.

Although it's difficult to say for sure, there are indications that the training module on upfront collections has contributed to the health system's success in that area, Consolver notes.

'Improvement Councils' build system-wide unity

Access group sets goals, tracks results

After Texas Health Resources (THR) was formed in 1997 from the merger of Fort Worth-based Harris Methodist Health System and Dallas-based Presbyterian Healthcare Resources, a series of councils was created to help foster "systemness," says **Patti Consolver**, CHAA, CHAM, corporate director of patient access.

Among other accomplishments, she notes, these Operations Performance Improvement Councils (OPIC) have led to the development of strong, collaborative relationships between members from across the health care system.

THR hospitals have a systemwide total of 2,405 licensed beds, and employ more than 17,700 people, she says.

The relationships fostered through the OPICs, Consolver adds, serve as the foundation for the successful implementation of THR's goals and priorities.

THR's Patient Access Services OPIC — made up of patient access directors from member hospitals and representatives from the compliance, legal, information technology, finance, and managed care departments — provided the impetus for a comprehensive on-line training program for the system's 600 access employees, she says. **(See story, p. 90.)**

That council meets monthly under the leadership of Consolver, who reports directly to THR's senior vice president of finance.

"Enhanced goal-setting and measurement through the definition of performance measures provides an essential roadmap for aligning our activity to the system goal," Consolver notes. "We are able to track key performance indicators on a monthly basis and report each goal with respect to measurement, key stakeholders, communication, and alignment with the organization's priorities."

For 2006, she adds, the group has identified the key performance indicators as duplicate medical record numbers, percentage of scheduled patients being preregistered, collections per patient, and cost per registration. ■

Upfront collections outside the emergency department (ED) totaled $35 million in 2005, she says, compared to just over $4 million in 1998, and $23 million in 2004. In the ED, upfront collections were almost $6 million in 2006, compared to $1 million in 1998 and $4 million in 2004.

"We have always been a strong upfront collector," Consolver points out, while noting that much of the credit for recent increases certainly goes to a strict new financial policy that has clarified the role of front-line staff.

"We were able to put [the new policy] together and roll it out to staff, so they were able to understand our expectations," she says. "It's easy to put a policy out on the web and say, 'This is it,' but if it's in a module, we know for sure it's being presented to everyone in the same way."

To further ensure that consistency, she says, the chief financial officers at THR hospitals took the module training as well, Consolver notes.

A 10th training module was added in 2006, she says, in conjunction with the implementation of a new Siemens registration system to replace both a homegrown system being used in THR's "west" hospitals (those that were part of Fort Worth-based Harris Methodist Health System) and an older Siemens system in use at the "east" hospitals (those that were part of Dallas-based Presbyterian Healthcare Resources).

To roll out Siemens' Envision Gold system to all the patient access departments, Consolver explains, "we created a module that went over all the screens and compared them to the old system. It is very interactive and self-explanatory, [saying], 'This is where you went in the current system, and this is where you'll go in the new one.'"

The module, which lasts about an hour and a half, is shown to employees before they go into an instructor-led training session, she adds, and has been instrumental in the implementation, which began in July 2005 and is ongoing.

Within the past year, Consolver notes, THR has received approval for employees who successfully complete the modules to gain CU hours from the National Association for Healthcare Access Management (NAHAM) that go toward its certified health care access associate (CHAA) and certified health care access manager (CHAM) designations. "We are so pleased with the modules," she adds. "I recently got an e-mail — from a new employee who wasn't sure who to direct it to — saying how wonderful the on-line training was, and how great it was to be able to access the material from home."

That individual, Consolver says, who actually was taking the training for the second time, added, "I'm amazed at what I didn't know that I thought I did."

(Editor's note: Patti Consolver can be reached at PatriciaConsolver@texashealth.org.) ■

Director toasts staff on 'New Year's Eve'

Achievements celebrated

Patient access staff at the University of Pennsylvania Medical Center-Presbyterian in Philadelphia scheduled a New Year's Eve party at the end of June as a way of celebrating their achievements during the just-ended fiscal year, says **Raina Harrell**, CHAM, director, patient access and business operations.

"What do you do at New Year's Eve parties? You reminisce about the accomplishments of the past year," Harrell notes, describing her plans for the first-time event, which was to be part of the monthly staff meeting.

"We'll have decorations all over the room and ginger ale in plastic champagne glasses at each place," she says. "There will be party hats and noisemakers and I'll be toasting the staff for a wonderful fiscal year, for all of their achievements and hard work. It's a form of rewards and recognition"

The idea behind the party was to find an entertaining way to help employees see "where all their hard work is going," she explains. "Sometimes the staff perception is that management is changing things just to change them. Sometimes managers keep their goals to themselves and just implement processes. What I'm trying to do is show them that we do have the big picture in mind, that the things we asked them to do helped us put these improvements into effect.

"A lot of times staff hear about the things we do not achieve, and about where we're going and what the next thing is," Harrell points out. "Often as managers we fail to go back and say, 'This is what we've done.' Or we [recognize improvements] one by one, when they occur. By doing it all at once, it's a lot larger."

Harrell identified 32 achievements, spread throughout admissions, emergency department (ED) registration, the business office, and medical

records and noted them on a large poster board. She's also put a description of each of the achievements on large stars, which employees will take turns pulling from a container, reading aloud, and later placing on the board.

Among the accomplishments being highlighted, she says, are the following:

- Integrated a new unit into the bed placement flow while still meeting admission targets.
- Achieved 98% accuracy in charting reports in medical records.
- Exceeded a 24-hour chart retrieval goal set at the beginning of the year.
- Implemented a flow coordinator position in outpatient registration.
- Reduced outpatient registration wait time from between 22 and 25 minutes to between five and seven minutes.
- Renovated the infusion suite registration area.
- Scrub (ensure accuracy of) 100% of ED registrations.

Included in the mix, Harrell says, will be a few lighthearted "accomplishment" listings, such as the baby that was born to one of the bed board operators.

Employees will get a copy of a flyer outlining the achievements, she adds, "so they'll each have their own personal brag book about the things their department has done in FY06."

"My big thing right now is motivating my staff, to have them feel the accomplishments that I see," Harrell says. "The object is for them to see the big picture, and to eliminate the silos."

Making 'resolutions'

Continuing the theme, the staff meeting at the end of July has been designated New Year's Day, Harrell says.

"Our theme for next year is 'Raising the Bar,'" she adds. "We'll be sitting and making New Year's resolutions. Managers will have identified their departmental targets — usually things like improving patient wait time or patient satisfaction scores — and will introduce those to staff so they can be onboard."

Employees will be asked to write resolutions regarding their individual work areas, Harrell says, which will describe "what their part will be" in achieving the goals of fiscal year 2007.

"It might be something that was discussed in the quality review and feedback they receive each week, or it may be to help a coworker do something," she suggests. "It could be a way in which they can impact the department manager's goal."

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Video conferencing streamlines ASL service

Hospitals can access it 24/7

Caregivers at Hamot Medical Center in Erie, PA, are using a video interpreting program that allows deaf patients "to be treated as quickly as anyone else," says **Barbara Magee,** RN, patient education coordinator.

With only two certified American Sign Language (ASL) interpreters in the area — one of whom lives 30 minutes away — it had often been difficult to make sure an interpreter was available to assist deaf individuals on a timely basis, she notes.

"Our staff would get very frustrated when they attempted to call and couldn't reach the small supply of interpreters," Magee says. A Pennsylvania law effective in July 2005 requires that hospitals use only interpreters certified by the state, she adds, which further limited the options.

With DT Interpreting, a service of DeafTalk LLC , hospital staff can access ASL interpreters 24 hours a day, seven days a week, Magee says. A recent collaboration with Sony Electronics involves that company's compact, all-in-one video conferencing system, which makes use of IP-based communications technology, she notes.

"We get the DeafTalk equipment cart and take it to the bedside, where someone dials an 800 number to set up an interpreter on the screen," Magee explains. "The voice of the person calling is picked up and transferred [to the interpreter] and there is a small camera on the patient.

"The interpreter and the patient sign back and forth, and the interpreter voices what the patient has said," she says.

Most rooms in the hospital's emergency department (ED) are wired for the service, with a special jack to connect the equipment, Magee notes. If the person needing the interpreter is in an inpatient bed, she adds, a second cart can be taken from floor to floor.

The service is actually more cost-effective than

using in-person interpreters, Magee says, because it can be accessed precisely when needed.

"Any time you're trying to arrange for an [in-person] interpreter, you don't always know exactly when the physician will be there, so you often need to keep the interpreter on hand for hours at a time," she points out. "Now, whenever the physician is there to give discharge instructions, discuss a surgical consent for an immediate procedure or talk about a diagnosis, the family comes in and they can talk immediately."

A community education meeting was held to help ensure that deaf individuals in the area would be comfortable with the service, Magee says. "We wanted to emphasize that we were not saying that we would not continue to find an actual interpreter, if that was what they preferred."

In some cases, deaf patients do want face-to-face interpretation, she adds, particularly if the person has a long history of working with a particular interpreter. Many times, however, they are more agreeable to using the video service because it allows a faster interpretation, Magee says.

"We just try to meet their requests and let them know we aren't mandating," she says. "Once they know it's a comfortable experience, some actually feel better not knowing the interpreter personally."

With so much emphasis in hospitals on patient safety and meeting the standards of the Joint Commission of Accreditation of Healthcare Organizations, Magee points out, "it's very important that patients who are deaf are treated as anyone else would be."

"They need to be able to pick pertinent information from the nursing or physician assessment so they can be given the most appropriate care," she adds. "With a form of communication that is quickly available, we're much better able to assess patient needs accurately and deliver that care in a timely manner." ■

Initiatives aim to enhance patient communications

AMA, NIH announce programs

A report offering guidelines to help health care organizations ensure effective, patient-centered communications with patients of diverse backgrounds has been released by the American Medical Association (AMA) Ethical Force Program.

Hospitals can use the report to identify areas of strength or weakness and focus resources where needed, according to a statement from the program, which is field-testing an organizational self-assessment toolkit based on the report.

The report separates organizational performance into six main areas and three "sub-areas." Quality improvement efforts to promote patient-centered communication could focus on any or all of these interrelated areas, which include:

- understand your organization's commitment;
- collect information;
- engage communities;
- develop workforce;
- engage individuals;
- sociocultural context;
- language;
- health literacy;
- evaluate performance.

It lists a number of specific, measurable expectations for performance in each of these areas — more than 50 in all.

The AMA's Institute for Ethics and Health Research and Educational Trust, an affiliate of the American Hospital Association, is conducting the program's initiative on patient-centered communication. More information is available at EthicalForce@ama-assn.org.

In another effort aimed at enhancing patient-provider communication, the National Institute on Aging, part of the National Institutes of Health, has published a guide to help older Hispanics communicate effectively with their physicians and other health care providers.

The Spanish-language publication also helps consumers choose a physician, prepare for an appointment, work with an interpreter, discuss sensitive health issues, and find additional information in Spanish.

A national program recently announced by the Robert Wood Johnson Foundation (RWJF) is designed to support hospitals in improving the quality and availability of health care language services for patients with limited English proficiency (LEP).

"Speaking Together: National Language Services Network" (NLSN) has four goals:

- To improve communication between patients with LEP and their health care providers.
- To work in partnership with hospitals to develop models of high-quality language ser-

vices.

• To develop useful measures in the area of language services to enable hospitals to conduct ongoing measurement of effectiveness and create performance benchmarks.

• To encourage the spread of successful strategies to increase language services within and across hospitals and health systems.

The core component of the program is a 16-month hospital learning collaborative aimed at fostering shared learning and innovation among participants. Sites selected to participate in the collaborative will receive grants of up to $60,000, as well as technical assistance and training using measures developed by the national program office (NPO). George Washington University Medical Center will serve as the NPO for this program.

Eligible sites are non-federal, general acute-care hospitals that have a minimum of 10,000 discharges per year and serve substantial numbers of patients with LEP. Hospitals must be operating a language services program that involves on-site professional interpreters. ■

Providence policies called 'fair, just'

Class-action suit settled

Providence Health System's charity care and financial assistance policies are "fair, just, and reasonable," according to a Multnomah County Circuit judge who gave final approval to the settlement of a class-action lawsuit.

Under the terms of the recent settlement agreement, Providence retroactively offered its current financial assistance policies and discount to uninsured patients who received medical care at Providence hospitals in Oregon since December 2001.

Providence's current financial assistance policies offer support to uninsured patients with limited assets and incomes at less than 400% of the federal poverty level. Patients with limited assets earning 200% or less of the federal poverty level — $40,000 for a family of four — can apply for free care.

Providence also provides a discount for all uninsured patients living in the geographic areas served by their hospitals, regardless of income, to the same "preferred provider" rates paid by most of its insured patients.

As part of the settlement, according to an article on the health system's web site, Providence's financial assistance team spent thousands of hours reviewing claims submitted by uninsured patients who received services at a Providence hospital in Oregon during the past four years.

That review, the article said, identified 250 patient claims entitled to refunds — totaling $194,385 — under the terms of the settlement. ■

JCAHO safety goals extend reporting rule

Among the major changes cited by the Joint Commission on Accreditation of Healthcare Organizations in its recently announced 2007 National Patient Safety Goals is the extension of a requirement that accredited organizations define and communicate the means by which patients and their families can report safety concerns.

New this year is a requirement that certain accredited organizations provide a complete list of medications to each patient upon discharge.

Behavioral health care organizations, including psychiatric hospitals and general acute-care hospitals treating patients for behavioral disorders, must now identify patients at risk for suicide. In addition, home health care organizations must identify the risks associated with long-term oxygen therapy, such as home fires. ▼

COMING IN FUTURE MONTHS

- Disaster victim locators
- Vanderbilt's 'Team Triage'
- 'Turnstile ED' program
- Inpatient preservice collection
- Access regulatory update

Collecting patient data linked to improving care

Hospitals and other health care organizations that collect data on patients' race, ethnicity, and language may be more likely to look at disparities in care, design targeted programs to improve quality of care, and provide patient-centered care, according to a recent article by researchers at the Health Research and Educational Trust and Northwestern University's Feinberg School of Medicine in Chicago.

The collection of such data, however, often is fragmented and incomplete, the authors say, largely because of a lack of understanding about how best to collect the information from patients.

They outline a framework for collecting race, ethnicity, and language directly from patients, which they say is usually more accurate than staff observation. The article appears in the August issue of Health Services Research. ▼

Ripe job market for health information coding staff?

According to a national staffing company, Kforce Professional Staffing, the national demand for health care labor coupled with the overhauling of the International Coding Directory (ICD) has created a market ready and waiting for coding professionals.

Group president of the company health information management division Sam Farrell says, "Hospitals already find it difficult to meet their needs for inpatient coders, outpatient coders, and coding managers, and now will be faced with the need to find staff who are prepared for the new ICD-10 standards. . ."

Inaccurate or untimely coding can cost hospitals a lot in revenue, he says, further emphasizing the demand for coders. And changes in the ICD-9 coding system, replacing it with ICD-10, compound the need for health information professionals.

Salaries have jumped in the last six years for these professionals. According to the American Health Information Management Association (AHIMA), the number of positions with annual salaries exceeding $40,000 has nearly doubled.

In fact 62% of coding professionals earn between $30,000 and $50,000 per year. Nearly half (49%) of managers earn between $40,000 and $60,000. Salaries are even higher for consultants contracted by a staffing firm. ■

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**. ■

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

Compliance with HIPPA privacy regulation is dropping

Survey says: Don't take compliance for granted

While the majority of health care facilities continue to essentially be in compliance with HIPAA privacy and security regulations, the number that consider themselves more than 85% compliant with the privacy regulation has dropped in the last year. That's one of the key findings in the American Health Information Management Association (AHIMA) 2006 survey — "The State of HIPAA Privacy and Security Compliance."

The percentage of respondents who said they believed their institution was more than 85% compliant dropped to 85% in 2006 from 91% in 2005. Likewise, the percent of respondents who believed they were less than 85% compliant increased from 9% in 2005 to 15% in 2006.

AHIMA analysts said that while this is not a significant change, it is enough to raise concern — especially given that 55% of respondents said that adequate resources are their most significant barrier to full privacy compliance. "Privacy officers particularly need support for education and training of new staff, while a lack of resources and competing priorities have led some hospital and health system staff to slack off regarding all aspects of the privacy rule," the survey report said.

"The issue of budget also appears to impact the level of privacy training and monitoring that a privacy officer or staff are capable of providing," the report continues. Finally, privacy officers report sensing a loss of support from senior management, both in ensuring that facility staff are aware of the need for privacy, as well as ensuring sufficient budget for education."

Dan Rode, AHIMA's vice president for policy and government relations, tells *HIPAA Regulatory Alert* it is becoming obvious that if organizations don't keep at it and reinforce behaviors necessary for compliance with the privacy regulation, it starts to lose meaning and bad habits from the past, such as leaving files open on a desk or talking about patients in an elevator, start to occur again.

"I think some things are going to happen" to bring more resources to bear on the issue, Rode says. "There have been a number of high profile incidents recently, like the loss of VA data and a Government Accountability Office report that there are serious security deficiencies in computer systems at the Department of Health and Human Services [HHS]," he says.

"These revelations are leading to discussions on how to keep records more secure. Privacy officers are trying to use these incidents to leverage their administration for more resources and support to do the job right."

Security compliance continues to increase

With the HIPAA security regulation, 25% of surveyed facilities indicated compliance at the top level, with another 50% saying they are close to full compliance. That represented an increase over 2005, when 17% of all respondents described themselves as "completely compliant" and 43% said they were 85% to 95% compliant.

"It appears that the security regulations were much easier to achieve than the privacy rule," AHIMA analysts said.

Three years after implementation of the HIPAA privacy rule, the AHIMA survey reached these conclusions:

1. HIPAA implementation has been a challenge for organizations, and it appears that for the majority the challenge has been met. However, the need for privacy, confidentiality, and security remain, especially as organizations tighten

staffing and budgets. A slight drop in the number of facilities reporting themselves to be fully or mostly compliant with HIPAA should serve as a warning to the industry that compliance should not be taken for granted.

2. If the support for privacy and security and the need for ongoing training are not maintained (and in a few areas increased), all the work that has been put into HIPAA compliance efforts over the last few years may be undone over time.

3. The need for support of privacy and security must also reach beyond facilities. The federal government's approach to HIPAA enforcement has been to educate rather than to fine or prosecute offenders. While we applaud this approach, a concerted effort to educate and remind the health care industry and others of the need to maintain and continually improve privacy efforts is equally needed.

4. The health care industry has much to learn from HIPAA as it moves toward electronic health records and a nationwide health information network. There is considerable disagreement on whether electronic health records will improve privacy or security and there are many concerns on how information networks will protect data. Consumers will be watching the health care industry to see how well it complies with HIPAA rules before they put their trust in a national health information exchange. Communicating with consumers, answering their questions, and addressing their concerns may be key to advancing health information exchange activities. Privacy officers and health information management professionals will be important partners in this process. AHIMA believes that the time is right for an open dialogue about the value of privacy at both the national and organizational levels.

Rode says, most providers are growing accustomed to the various provisions of the privacy rule, but there still are reports of difficulties with specified requirements. Many respondents would like to see changes in the accounting for disclosure provision of the privacy rule. Most commonly, he says, respondents have received at most a few requests for an accounting.

He says that for many respondents the provision is not only burdensome but also significantly inefficient. The problem could easily be addressed while ensuring that individuals would have an accounting for all releases not covered by authorization or law. A major impediment, he says, is that most organizations still are paper-based and it's hard to deal with a complete accounting in a paper environment.

According to Rode, health care organizations and the general public remain in a HIPAA transition period, even three years after implementation, and the transition will continue until there has been a major adoption of electronic health records. He says that many of the issues that are problems today can be resolved easily when there is a critical mass using electronic records. "But we're still moving slowly," he concluded. (Download the AHIMA report at www.ahima.org/emerging_issues/2006StateofHIPAACompliance.pdf. Contact Dan Rode at (312) 233-1100.)

Still no privacy fines

The mainstream media has picked up on the fact that enforcement of the HIPAA privacy regulation has not included any civil fines and only two criminal prosecutions. The *Washington Post* catalogued 19,420 grievances filed in the three years since protection for private medical information took hold, with more than 14,000 of the cases closed by the government, "either ruling that there was no violation or allowing health plans, hospitals, doctors' offices, or other entities simply to promise to fix whatever they had done wrong, escaping any penalty."

The *Post* reported the most common allegations have been that personal medical details were wrongly revealed, information was poorly protected, more details were disclosed than necessary, proper authorization was not obtained, or patients were frustrated getting their own records.

"Our first approach to dealing with any complaint is to work for voluntary compliance," said Department of Health and Human Services Office of Civil Rights Director **Winston Wilkinson**. "So far, it's worked out pretty well."

Hospitals, insurance plans, and doctors may agree with Wilkinson's assessment, but it has been strongly criticized by privacy advocates and some health care industry analysts who say the Bush administration's decision not to enforce the regulation more aggressively has not safeguarded sensitive medical records and has made providers and insurers complacent about compliance.

"The law was put in place to give people some confidence that when they talk to their doctor or file a claim with their insurance company that

information isn't going to be used against them," Health Privacy Project founding Director **Janlori Goldman** told the *Post*, "They have done almost nothing to enforce the law or make sure people are taking it seriously. I think we're dangerously close to having a law that is essentially meaningless."

The *Post* said the debate has intensified because of a government push for computerized medical records to improve health care efficiency and quality. Privacy advocates have expressed concern that large, centralized, electronic databases will be especially vulnerable to attack, making it even more important that safeguards be vigorously enforced.

Don't know if fines are needed

Wilkinson declined to discuss specific cases but said his staff have "been able to work out the problems. . . by going in and doing technical assistance and education to resolve the situation. We try to exhaust that before making a finding of a technical violation and moving to the enforcement stage. We've been able to do that." He said that with some 5,000 cases still open, there might be a need for some fines but "we don't know at this stage."

Those responsible for complying with the law generally praise the HHS approach to enforcement. "It has been an opportunity for hospitals to understand better what their requirements are and what they need to do to come into compliance," said the American Hospital Association's **Lawrence Hughes**. And American Academy of Family Physicians President **Larry Fields** said physicians "are more used to the government coming down with a heavy hand when it's unnecessary. I applaud HHS for taking this route."

But health care consultants say the lack of penalties has led to organizations becoming complacent about protecting patient records. They cite the latest AHIMA survey.

"They are saying 'HHS really isn't doing anything so why should I worry?'" said Apgar & Associates consultant **Chris Apgar**.

Wilkinson said the limited size of his staff prevents them from doing more than to respond to complaints. "We've had challenges with our resources investigating complaints," he said. "We've been successful with voluntary compliance, so there has not been a need to go out and look."

The privacy advocates counter that other federal agencies, such as the Securities and Exchange Commission and Federal Trade Commission, take a different approach, looking for significant and high profile cases that will send a message to industry.

"The law came about because there was a real problem with people having their privacy violated," Goldman said. "They lost jobs, they were embarrassed, they were stigmatized. People are afraid. The law was put in place so people wouldn't have to choose between their privacy and getting a job or going to the doctor. That's still a huge problem." ■

Texas court allows info release despite HIPAA

Statistics about sexual assaults must be released

A four-judge Texas Court of Appeals panel has ruled the state Department of Mental Health and Mental Retardation must release statistics about alleged sexual assaults at state mental hospitals that were requested by journalists. The judges said the Texas Public Information Act allows release of the data and state officials can't withhold it because they believe it is protected health information under HIPAA.

"This opinion gives important guidance to every Texas governmental body that is faced with a public information request for medical information where HIPAA applies," said state attorney general spokesman **Tom Kelley**.

The department had refused to release the information citing HIPAA requirements, and then asked the attorney general for an opinion. The attorney general concluded the information had to be released because the HIPAA privacy rule allows disclosure of health information "if required by law." The department appealed and a Texas county district court judge sided with the agency. The attorney general then appealed to the Court of Appeals.

The Appeals Court judges said they believed the information requested — statistics on alleged sexual assault and abuse incidents at state hospitals, subsequent investigations, the names of facilities where incidents occurred, and the outcome of any investigations — does not fall under the definitions of protected health information in

either HIPAA or the privacy rule.

"Statistical information regarding allegations of abuse and subsequent investigations does not seem to relate to issues regarding health or condition, in general, and certainly does not relate to the health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual" the judges wrote. They noted their interpretation of "protected health information" is supported by decisions in other courts, including an Ohio Supreme Court ruling dealing with copies of lead contamination notices sent to residences of children whose blood tests had indicated elevated lead levels.

However, the judges said, since both parties had taken positions based on the belief that the requested information was protected, their ruling was based on the same assumption. The judges rejected the department's position that the records law is not included in the "required by law" exception to non-disclosure in the HIPAA rules because the commentary on the rules did not specifically list open records laws as laws requiring disclosure.

Court rejected several arguments

Justice **David Puryear** wrote for the court that "nothing in the definition of 'public information' expressly exempts health information" from the open records law and that the "commentary merely provides a range of possible areas of law that might require disclosure." He said the commentary also makes clear that in a federal Freedom of Information Act request, agencies should look to the law's exemptions, rather than to HIPAA's, to decide if the information should be released.

The court also rejected the department's argument that although the information requested was not explicitly deemed confidential under HIPAA rules, it should be considered confidential because HIPAA does not provide for its disclosure. "We cannot adopt this circular logic," Puryear wrote. "Our construction of the statutes properly balances the need for privacy under HIPAA. . . and the need for disclosure under the Public Information Act and correctly reconciles these two statutes."

Meanwhile, members of Congress have been debating a need for HIPAA to preempt state laws. The Health Information Technology Promotion Act of 2005 introduced by Rep. Nancy Johnson (R-CT) and Rep. Nathan Deal (R-GA) would establish federal privacy protections that could override inconsistent and varying state privacy laws. Observers have noted that many state laws are more stringent than HIPAA and other federal privacy rules, and rules in one state often conflict with rules in another state.

The override provision drew praise from American Medical Informatics Association CEO **Don Detmer**, who said he doesn't believe it is possible to get to common standards and interoperability that underlie the widespread adoption of electronic health records without federal preemption of conflicting state laws. He said he was pleased the legislation calls for an HHS study of standards adopted after HIPAA.

"If the study shows that varying state laws and requirements have a negative impact on health care delivery, quality, and access," he said, "and that HIPAA has established meaningful privacy and security protections, it makes sense to move forward without delay on federal preemption for all adopted HIPAA standards."

But that position was challenged by Consumers Union senior policy analyst **William Vaughan**, who said the American public will not support, fully use, or benefit from the great potential of electronic medical records until more is done to ensure the privacy, security, and appropriate use of medical information. "This requires enabling patients to decide when, with whom, and to what extent their medical information is shared," he said.

He said the American public needs to be given meaningful control over their medical rights, having a right to keep their records private and not be forced to give up control of their most private medical information as a condition of treatment. He called for more aggressive enforcement of privacy violations, saying current penalties are inadequate and have major gaps.

And Vaughan said states "should have the right to enact privacy laws above and beyond HIPAA's absolutely minimal provisions and that right must not be preempted. Privacy needs to be strengthened, not weakened, and we urge you to oppose legislation that would preempt stronger state laws or delegate to the secretary of HHS authority to preempt such laws. These state laws offer extra protection and peace of mind to patients with mental health, sexually transmitted disease, cancer, and other treatment issues." ■