Hospital Access Management™

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

AHC Media LLC

IN THIS ISSUE

NOVEMBER 2006
VOL. 25, NO. 11 • (pages 121-136)

Physician buy-in, designing EMR are focus of Texas system's next phase

Allowing providers 'a choice of tools' crucial to success

As Southern Texas Hospital System (STHS) moves forward with the implementation of its regional health information organization (RHIO), the focus must remain on its ultimate purpose — patient-centric collective data — and on creating value for each stakeholder, says **Shannon Calhoun,** executive director for the Goliad-based organization.

"There is no absolute, specific definition of the parameters of what a RHIO can do," Calhoun points out. "So RHIOs can be information exchanges, can be information sharing, can be collective information — and can happen through a host of different technologies, all of which have to address interoperability."

The first steps in the STHS project were to establish a secure data center and to begin addressing the technology and relationships supporting the technology, she adds; creating a smart card was the beginning piece of those technologies. **(See related article, *Hospital Access Management*, September 2006.)**

With assistance from a federal grant, STHS connected five of its eight hospitals through software to a central data repository that allows patients to carry a card with a microprocessor chip containing their personal health summary.

The next piece had to do with clinical information supported by an electronic medical record (EMR), Calhoun says. "We are pursuing funding and relationships and technology to allow us to do that with economies of scale.

"The question there would be how to raise the level of use of EMRs in the community in an affordable manner and still provide for the technical support and choices of the provider," she adds. "EMRs are tools for providers, and one does not want to take away the choice of tools that a particular provider would use.

"While attention has been given to getting smart cards in the hands of consumers, and hospital staff have rallied around the efficiencies the

cards can facilitate, it is crucial to have the support and participation of physicians," Calhoun says. "How long will you carry a card every day if it's only usable at hospitals?

"The purpose of the EMR is that we really need to have data, not only from the hospital but from the physician," she says. "If [information] comes directly from the physician and is burned on the card, it is more accurate and precise than if the patient is giving the answer as to what medications he or she is on.

"Right now, that information comes from the patient, not the physician," Calhoun adds. "We need to have EMRs working with the smart card in order to raise the level of trusted, accurate information. As it becomes more automated, it becomes less complicated."

There is also the question of how information systems talk to one another, she says. "Say I went to a general practitioner and then to a cardiologist; how do you get the data in one place to the other and have the patient's information at one point? That is being patient-centric.

"We don't want to have [the patient] record exist only at the data center and everybody has to log in," Calhoun notes. "There are unified and federated RHIOs. We're sort of a hybrid."

The next phase of STHS's RHIO project will involve meeting with physicians in the medical communities that support each of its member hospitals and demonstrating the advantages of their participation, Calhoun says.

For example, while an EMR is typically thought of as a way to efficiently store patient data, she notes, it also can be a resource for supporting all of the things that a physician might know and use. "Think of the Physicians' Desk Reference [being included], the ability to have prompting to prescriptions that you use regularly, and having those red-flagged to a person's age and weight."

The question to be posed to physicians and other providers, she says, is, "What do you need in your toolbox?"

"An EMR has become a huge resource tool to allow automation of a host of things a physician does with paper today," she says. "One we've looked at shows a picture of the body that allows the user to look at the circulatory system. That can be an educational tool for the physician to use with a patient."

A cardiologist or a surgeon, for example, might want more specific information related to those specialties, Calhoun says, but would not need the variety of CPT codes that would be used by a general practitioner.

"As an organization, we would not want to presume what any one of those physicians can use, but should set parameters and make an offering of what we could provide and support."

Another value-added piece for physicians in phase two of the project is the automation of physician orders, she says. Practitioners will be able to enter their orders into some sort of software, Calhoun adds, whether through the EMR or through a practice management system that interfaces with the smart card software or directly into the smart card software.

"When the patient goes to the hospital and

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

Subscriber Information

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

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

Editorial Questions

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

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

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

swipes in the card, the orders are there," she says, adding that STHS is also beginning work on communicating patient signatures and precertification in the same way.

"Interoperability and interfaces [are key]," Calhoun says. "Once [the system] interfaces with payers and government and employers — they are also stakeholders — that rounds out the ability to create a patient-centric system."

(Editor's note: Shannon Calhoun can be reached at scalhoun@goliad.net.) ■

Enhance communication with 'positive psychology'

It's about 'what can go right'

The emerging science of positive psychology offers access managers myriad ways to maximize staff potential, build effective teams, and boost employee morale, says **Susanne Gaddis,** PhD, a consultant and keynote speaker based in Chapel Hill, NC, who specializes in health care communication.

Positive psychology — founded in 1998 and currently the subject matter of the most popular elective at Harvard University — is about "what can go right with people, as well as what can go wrong," says Gaddis, who spoke at the 2006 North Carolina Association of Healthcare Access Management (NCAHAM) conference in Asheville, NC.

The science of positive psychology is supported by academics worldwide, as well as by many grants and organizations, Gaddis notes, including the World Health Organization (WHO) and the National Science Foundation. The University of Pennsylvania now offers the first master's of applied positive psychology program in the world, she says.

A web site (www.authentichappiness.org) devoted to the subject offers tests based on positive psychology that measure everything from your current emotional state to your happiness quotient, she says.

Access managers could, for example, identify their key strengths, along with those of their employees, with the Values in Action (VIA) Signature Strengths survey that looks at 24 character strengths and virtues that all human beings have, Gaddis says.

"At the end of the test, you receive a printout of your top five strengths," she adds.

Zest and enthusiasm constitute one of her key strengths, Gaddis notes. "I get excited about anything — if you have a pogo stick, if the leaves are changing; when I can be zesty, I'm happiest. So if I have a job where the boss is trying to twist that zest out of me, I feel like I'm being robbed of the best part of me.

"My sister's strength is curiosity," she says. "My whole life I thought my sister was nosy. If you have an employee who is naturally curious, maybe you put that person on a research project."

A friend whose top strength is bravery once wrestled a bear, Gaddis says. "I asked him, 'Why would you wrestle a bear?' He said, 'Because I could.'"

Working with a pharmaceutical development company in Florida, Gaddis used the test to help each person on a sales team identify his or her key strengths.

"It just so happened that the top strength of the sales director is forgiveness and mercy," Gaddis says. "He is also brave, a trait the CEO also has and why they get along."

Soon after the session, she adds, someone on the sales staff made a huge mistake that could have cost the company a couple of million dollars. The sales director was upset, Gaddis says, "but once he said he was upset and why, he was over it."

"Instead of harboring ill will, he was truly over it," she adds. "He just needed to vent and say, 'Never do that again.'

"The sales staff were able to see this strength, dialogue among themselves, and say, 'He probably is over it, and we just need to go on with things, too.'"

Without the knowledge provided by the testing session, Gaddis says, they might wonder if he had really put the incident behind him.

Social intelligence, which is about being aware of the motives and feelings of other people, is a key strength that would serve someone who is in access services well, she notes. "You have to know how to work with different personality types and how to modify your style to fit the needs of those you're serving. It's being aware of what's being said and the feelings behind what's being said."

Socially intelligent people know what to do verbally and nonverbally in situations to keep people calm and invested, Gaddis says.

"I would want a person on the registration desk who — if he or she noticed somebody huffing and puffing and shifting weight — could look

up and say, 'I'll be right with you. Thank you for being so patient.'"

Industry and perseverance — finishing what one starts — is another key strength that would be welcomed in an access employee, she points out. "This is someone who would be fighting like a bulldog to get that last piece of information in the right box."

A manager putting together an access team for a particular project might want to choose someone brave and another person with self-control and self-regulation, and so on, Gaddis says. "You might want a zesty person working with a prudent person."

The information the tool provides "lets you reframe what is going on," she adds, and gain perspective on where people are coming from.

Of the many different positive psychology tools available, Gaddis says, she particularly likes one called "Active, Instructive Responding," developed by Shelly L. Gable.

"[Gable] has done research on how people respond when they hear good news," she explains. If, for example, you say to a colleague, "Hey, I got that report done," the responses could vary as follows, depending on the category into which the person falls.

- **Active, constructive response.** "I will engage with you, drop what I'm doing, and you will become the most important person in the room. My response might be, 'Oh, my goodness. That is fantastic. I'm so excited for you.'"
- **Passive, constructive response.** "I respond, but my response is extremely short and abrupt. I might make a little eye contact and say, 'Oh, great,' but the response doesn't really give you what you need. Your feeling might be that I heard you, and I did respond, but do I really think it's great? This could get awkward if you go back and say, 'Didn't you hear? I got the report in.' And then I say, 'I told you it was great.'"
- **Active, destructive response.** "I say, 'It's about time you got that done. How long have you been working on it?' I'm a joy robber. I take the good energy away."
- **Passive, destructive response.** "I don't respond directly to what you've said, but say something like, 'So what are we doing tonight?'"

Such response patterns "are habitual behaviors modeled from the people who raised you," Gaddis says, "but they can be broken and relearned. Science shows we are not stuck in behaviors that are not working, and that strengths change over time as we age."

One of her favorite illustrations of positive psychology, she notes, is the account of a New York reporter asking golfer Tiger Woods, "What's the worst part of your game?" Woods replied that, without a doubt, the worst part of his game is hitting the ball out of a sand trap.

The reporter says, "So I bet you spend a lot of time practicing hitting the ball out of a sand trap." And Woods answers, "No, I spend my time making sure the ball doesn't go into a sand trap."

[Editor's note: Susanne Gaddis can be reached at (919) 933-3237 or by e-mail at gaddis@communicationsdoctor.com. Her web site is www.communicationsdoctor.com. More information on the science of positive psychology is available at www.positivepsychology.org.] ■

'Toccare' theme continues with new cancer center

Patient comfort is focus

The recently opened cancer center at Mt. Graham Regional Medical Center offered the perfect opportunity for the Safford, AZ, facility to expand on its institutional theme — "Toccare Lo Spirito" or "To Touch the Spirit" — says **Julie Johnson,** CHAM, the hospital's director of revenue cycle management and HIPAA privacy officer.

From the access services perspective, she notes, the cancer center is an area where the focus is less on accuracy and speed of registration and more on providing a caring atmosphere for the patient.

"Nothing is lost, but we spend more time on these patients," Johnson says. "If someone is coming in for a repeat visit, the [registrar] might just greet the patient by name and say, 'You haven't moved since the last time you were in, have you?' If the patient is in a talkative mood," she adds, "the registrar might come out and speak with the person for a moment or two."

The registrar who has become the "face" of the cancer center is Jodi Ybarra, who has worked with Mt. Graham's chemotherapy patients for several years, Johnson says. "She is warm, concerned, friendly, and genuine."

Ybarra will leave her registration post to sit next to a new patient in a private area — rather than at a desk — and record the necessary information on a clipboard, she says. "It's important to

be one-on-one. They do get correct registrations, but the focus is on the comfort of the patient."

When the volume increased so that a second registrar was needed, Johnson adds, that person, Debra Dicus, was chosen because of her customer service skills and her desire to be in that environment.

"Many of the chemotherapy patients know her because she previously worked in the laboratory, where they had to have lab work done prior to, or sometimes after, treatment," she says. "So her's is another face that patients recognize and are comfortable with."

The registrars take new patients on a tour of the facility before handing them off to a nurse, who introduces them to the physician, Johnson says.

The infusion room — where patients may spend eight hours or more — faces Mt. Graham, the 10,000-foot peak for which the hospital is named, she says. "There are picture windows from floor to ceiling and the most comfortable chairs. It is so calming and peaceful."

Quilted laptop coverlets, handmade by members of the hospital auxiliary, hang on a bar on the back of the chair, for patients to use during treatment and even take home if they wish, Johnson says.

Interior decorating for the center — which features landscapes and desert colors, including deep purple — was done gratis by the wife of the chief operating officer, she adds.

Although the hospital campus is relatively small, Johnson notes, the cancer center is about a block uphill from the main facility, so golf carts were purchased to help move patients and supplies back and forth when necessary.

"[The carts] help with patients who have to go to hospital for a blood test or some other purpose before treatment," she says, adding that security personnel and a couple of other employees do the driving.

The cancer center enables Mt. Graham patients to have chemotherapy close to home, rather than drive two-and-a-half hours to Tucson or about three hours to Phoenix, as was previously necessary, Johnson notes.

A community survey conducted before the center opened determined that chemotherapy services would be used by area residents, but did not show a similar need for radiation therapy to be provided locally at that point, she says. "Our next focus will be to keep radiation patients from having to [make that drive] to get treatment. We're looking at doing that within the next year."

Space for specialty physicians

While the west side of the new facility is devoted to the care of Mt. Graham's cancer patients, at present, space on the east side is rented to outside specialty physicians, Johnson explains. "We have audiologists or cardiologists who might come in [from another city] and hold a clinic. We have a urologist who does procedures inside the hospital on some days and on other days holds a clinic here so patients don't have to go to Tucson for those appointments.

"If we get to the point where we need the entire cancer center for our patients," she adds, "those physicians can be moved to a new location on campus."

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

ACCESS FEEDBACK

Disaster victim locator poses access challenge

What if you don't have patient's name?

What happens when — in the wake of a disaster — hospital personnel are dealing with an influx of patients, many of whom have not been identified by name? How do access employees help family members who are trying to locate their missing loved ones?

Those questions are at the heart of a challenge presented to **Gillian Cappiello,** CHAM, senior director for access services and chief privacy officer at Swedish Covenant Hospital in Chicago.

"I was asked by our safety officer to develop a victim locator policy as part of our application for HRSA [Health Resources and Services Administration] funds," Cappiello explains. "The Chicago Department of Public Health requires that the hospital incorporate a process for locating patients in our emergency and disaster management plan."

The passage that specifically addresses that requirement reads: "Locating the whereabouts of

a loved one is a normal response and often becomes a consuming activity for survivors. Hospitals and hospital staff can become quickly inundated with telephone calls and onsite presentation of family and friends attempting to find their lost mother, father, sister, brother or friend.

"After 9/11, St. Vincent's Hospital in New York had more than 5,000 loved ones present to the hospital in attempts to locate missing persons," the passage continues. "It is with this understanding that it is in the hospital's and community's best interest to develop a psychosocial disaster plan, which clearly describes the hospital process in victim location activities."

Swedish Covenant has a specific agreement with the American Red Cross regarding the release of patient names and information, which basically calls for releasing only the minimum necessary, Cappiello says. "In a disaster you have to weigh what is in the best interest of the patient, family, and community."

However, she adds, with this project she is not talking about releasing the *names* of victims. "If we have someone of that name, then that is like [the person is in] the patient directory and we can tell those who are inquiring that the person is here and give the condition in general terms.

"If we don't have anyone with that name but we have John Doe, we can ask for physical description, such as sex, age, height, hair, and eye color, identifying features, and clothing," she says.

One of the solutions Swedish Covenant is pursuing is the development of a web-based resource, similar to the one it uses for physician referrals, Cappiello says.

Instead of entering physician preferences (such as specialty, gender, office location, languages spoken, etc., and looking for a match), she notes, the user would enter what is known about a victim, such as gender, age range, race/ethnicity, item of clothing (i.e., black pants), and whether, for example, the person has a tattoo or body piercing.

Cappiello seeks feedback from her fellow access professionals on any of the issues involved in identifying victims and connecting patients and families during large-volume disaster situations, including answers to the following questions:

• Do you get a log of patients — perhaps have them sign in — even before triage?

• Do you gather information, such as eye color, hair color, what the person is wearing or whether there are piercings or tattoos in order to help with identification if the patient is unable to provide his or her name?

• What other steps might you take if someone is inquiring about a possible victim and you don't have the name? If you think you have someone who matches the description, then what do you do? How do you connect the inquiring person with the individual you think might be a match?

• Do you ask if the friend or family member wants to see that individual? Do you involve an emergency department physician or nurse, perhaps a chaplain?

• Do you take photographs to help in the identification process?

Determining patient share

Cappiello also would like feedback regarding methods for accurately calculating, based on payer contract, the patient's share of the hospital bill so that staff are able to quote a fairly precise figure, rather than a huge range.

"Are other [access departments] getting a lot of inquiries from patients who have PPO plans that the facility contracts with?" she asks. "If the patient is coming in for, say, a $2,500 MRI, we know about the deductible, but are [other facilities] using any software to determine, based on the contract with the payer, what the patient share is?"

Complicated, varying terms from different payers make it hard to answer, Cappiello notes, when the patient asks, "What is the rest of my out-of-pocket cost going to be?"

[Editor's note: If you have feedback on this or any other topic of interest to access managers, please contact Editor Lila Moore at (520) 299-8730 or lilamoore1@msn.com. Gillian Cappiello can be reached at GCappiel@schosp.org.] ■

ED delays 'will come back to bite' hospitals

Patient death ruled homicide

The death of a patient who waited nearly two hours in the waiting area of an Illinois hospital emergency department (ED) was ruled a homicide by a Lake County coroner's jury, and the incident likely would be viewed as a violation

(Continued on p. 131)

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

CORE rules will build on HIPAA

Rules deal with No. 1 administrative complaint, 'access to eligibility and benefits information'

More than 90 health care organizations have come together to develop and implement operating rules for electronically exchanging eligibility and benefits information to make it easier for physicians and other health professionals to verify patient insurance information.

The new rules were developed under the leadership of the Council for Affordable Quality Health Care (CAQH), a health care industry collaboration that seeks to simplify and streamline health care administration. CAQH's executive director, **Robin Thomashauer,** tells *HIPAA Regulatory Alert* the change will be a major step away from the current situation in which physicians have had to approach each health plan they deal with individually and have not been able to obtain consistent information from each plan. "The No. 1 administrative problem we hear about is access to eligibility and benefits information," Thomashauer says. "It's a lot of work for providers."

By March 31, 2007, participating organizations, such as Aetna, Blue Cross Blue Shield of North Carolina, Humana, Mayo Clinic, Montefiore Medical Center, and WellPoint and its 14 Blue-licensed subsidiaries, will electronically exchange eligibility and benefits information under the CAQH Committee on Operating Rules for Information Exchange (CORE) operating rules. The rules build on existing standards, such as HIPAA, to make electronic transactions more efficient, predictable, and consistent, regardless of the technology used.

Thomashauer says the inspiration for the new operating rules came from the financial services industry, which has found ways to process ATM transactions, direct deposits, and other activities using operating rules that are independent of specific hardware or software.

"We didn't want all the health care organizations trying to address this problem to end up going down parallel tracks," Thomashauer tells *HRA*. "We're taking the work done to date on HIPAA and making it more robust so providers have adequate information with which to make decisions."

"Well-developed and widely used information standards are central to realizing our national goals for better quality and efficiency," says former Department of Health and Human Services National Coordinator for Health Information Technology **David Brailer**. "The CORE standards can simplify health care administration and improve the experience of America's consumers at a critical time in their lives."

Phase I elements

The CORE Phase I operating rules build upon the HIPAA 270/271 transactions for eligibility and benefits and address these information elements:

- system connectivity safe harbor standard (HTTP/S);
- standard inquiry acknowledgements;
- maximum response times (batch and real-time);
- minimum hours a system must be available (system availability);
- Standard 270/271 companion guide flow and format;
- data content, service type codes, and patient financial responsibility; and
- standard testing, certification, and enforcement processes to ensure CORE compliance.

According to CAQH, operating rules typically don't specify technology or tools that must be used in communicating information. Instead, they govern how that information is exchanged. Any entity that agrees to follow the CORE Phase I operating rules will be able to provide the eligibility and benefits data as outlined in the CORE Phase I

rules. Thus, health care providers will select the technology system of their choice and use that system as the connecting point for routing their eligibility and benefits inquiries to payers with whom they have trading partner relationships. Given this, CAQH says, the more payers, vendors, providers, and others who become CORE-certified will enhance the benefits the industry can gain from adopting the CORE Phase I rules.

Voluntary solution

"Use of the CORE rules is voluntary," CAQH says. "Stakeholder entities that wish to adopt the rules are required to sign a pledge committing them to ensure that their IT systems can perform according to the CORE rules. A CORE-authorized vendor will certify that each entity's system(s) complies with the CORE rules. Once an entity obtains its respective CORE seal, each entity can market itself as CORE-certified or a CORE endorser. Any entity that agrees to follow the CORE operating rules will be able to exchange eligibility and benefits information outlined in the rules."

Thomashauer says the intent is for CORE to cover several phases. Phase I will help providers determine which health plan covers the patient, determine patient benefit coverage, and confirm coverage of certain service types and the patient's co-pay amount, coinsurance level, and base deductible levels (as defined in the member contract) for each of those types.

She says Phase II will add another transaction and then additional transactions will be added in future years. This fall, she says, stakeholders were close to agreeing on the scope for Phase II. Once agreement is reached, work would begin with a goal of approving Phase II operating rules in the second quarter of 2007.

A key to success, Thomashauer says, is to ensure agreement among all the stakeholders who are involved. "We learned from the financial services industry that if you don't have everyone involved and working together, someone won't agree," she says. "We didn't move forward until everyone was in agreement. And you need to have approval at every level before you move forward."

Because CORE will be certifying organizations, participants will be guaranteed that they are receiving data that are consistent with the CORE rules. Thomashauer says it was important to have an initial critical mass of major players supporting the project. They can then take the issue to their trading partners and encourage them to become involved so that it will become a voluntary industry standard.

More info is available on-line at http://www.caqh.org. Contact Robin Thomashauser at (202) 861-1492. ■

Former Cleveland Clinic worker charged with fraud

A former employee of the Cleveland Clinic and Health Management Associates and her cousin have been indicted by a federal grand jury in Miami on charges of identity theft, computer and health care fraud, and violating HIPAA in a conspiracy involving nearly $3 million in fraudulently submitted Medicare claims.

U.S. Attorney **Alexander Acosta** announced the eight-count indictment of **Fernando Ferrer, Jr.**, and **Isis Machado**, whom he accused of stealing identification information from 1,100 patients and using it to falsely bill Medicare for $2.8 million in claims. Machado was employed at the Cleveland Clinic's Weston, FL, office from May 2005 until June 2006 as a front desk coordinator with access to confidential computerized patient information.

Prosecutors said Machado sold the information to her cousin, Ferrer, who owned Advanced Medical Claims, a Naples, FL, billing firm. In May 2006, the Cleveland Clinic sold its 70-bed hospital and 70-physician group practice in Weston to Health Management Associates, which also is in Naples. Prosecutors said the fraudulent practices continued after the sale.

The case reportedly is the first in south Florida and the third in the nation in which HIPAA violations are alleged for wrongfully disclosing private patient information.

Acosta said the case represented "an unwholesome criminal trilogy of medical privacy violations, identity theft, and health care fraud. In a rapidly expanding world of electronic medical records, preserving the privacy and integrity of confidential patient information is critical."

The two could be sentenced to 30 years in prison and fines totaling $750,000 each.

Acosta praised the Cleveland Clinic for reporting the incident quickly and cooperating in the federal probe. Cleveland Clinic spokeswoman **Eileen Sheil** issued a news release saying that the actions Machado was charged with were unau-

thorized and potentially criminal. She also said the identities of the 1,100 patients could be at further risk

"The Cleveland Clinic deeply regrets this incident as patients and visitors place their trust in our employees and staff," Shiel said.

GAO finds many agency privacy breaches

According to the Government Accountability Office (GAO), some 40% of health insurance contractors and state Medicare/Medicaid offices experienced data breaches in the last two years. GAO made the finding in an analysis of domestic and offshore outsourcing of personal information in the Medicare, Medicaid, and Tricare programs.

GAO did the study because federal contractors and state Medicaid agencies may contract with vendors to perform services involving use of personal health data, and thus outsourcing and privacy protections are of interest.

The agency surveyed all federal Medicare and Tricare contractors and all state Medicaid agencies (a combined total of 378 entities) to examine whether they (1) outsource services and (2) must notify federal agencies when privacy breaches occur.

Survey response rates ranged from 69% for Medicare Advantage contractors to 80% for Medicaid agencies. Among those that completed GAO's survey, more than 90% of Medicare contractors and state Medicaid agencies and 63% of Tricare contractors reported some domestic outsourcing in 2005. Typically, the report says, survey groups reported engaging from three to 20 U.S. vendors. One federal contractor and one state Medicaid agency reported outsourcing services directly offshore. However, some federal contractors and state Medicaid agencies knew that their domestic vendors had initiated offshore outsourcing.

Some 33 Medicare Advantage contractors, two Medicare fee-for-service contractors, and one Medicaid agency indicated that their domestic vendors transfer personal health information offshore, although they did not provide information about the scope of personal information transferred offshore.

GAO said the reported extent of offshore outsourcing by vendors may be understated because many federal contractors and agencies did not know whether their domestic vendors transferred personal health information to other locations or vendors.

"In responding to GAO's survey, over 40% of the federal contractors and state Medicaid agencies reported that they experienced a recent privacy breach involving personal health information," the GAO report said. "By survey group, 47% of Medicare Advantage contractors reported privacy breaches within the past two years, as did 44% of Medicaid agencies, 42% of Medicare fee-for-service contractors, and 38% of Tricare contractors."

GAO recommended that the Centers for Medicare and Medicaid Services (CMS) require state Medicaid agencies and all Medicare contractors responsible for safeguarding personal health information to notify CMS of privacy breaches. That type of requirement already exists for TRICARE and Medicare fee-for-service contractors, the report said.

CMS concurred with the GAO recommendation and cited examples of what it already was doing to make the change. The Department of Defense also concurred with the findings as they applied to Tricare.

The report said a privacy breach occurred in 2004 when a vendor hired to collect data from patient surveys in California outsourced the task to another vendor, who designed a survey in such a way that patients could see others' personal information. An offshore vendor for another project reportedly blackmailed the agency with threats of disclosing patients' personal information unless they received payment for their transcription services.

The report is available on-line at http://www.gao.gov/cgi-bin/getrpt?GAO-06-676. ■

Groups suggest basic principles for PHI privacy

Basic principles need to be incorporated in all rules, regulations, or laws pertaining to personal health information (PHI) if it is expected to flow across organizational boundaries through the nationwide health information network, according to the American Medical Informatics Association (AMIA) and the American Health Information Management Association (AHIMA).

"Public confidence that personal health information will be respected and that identifiable information, to the maximal extent possible, will be used

only for authorized purposes is essential to the success of any electronic health information exchange," said AMIA President **Don Detmer**. "Health information confidentiality and security protections must follow PHI no matter where it resides."

The two associations said organizations accessing or storing PHI should follow these principles:

- Inform individuals, through clear communications, about their rights and obligations and the laws and regulations governing protection and use of PHI.
- Notify individuals in clear language about the organization's privacy practices and their rights in cases of breaches.
- Provide individuals with a convenient, affordable mechanism to inspect, copy, or amend their identified health information/records.
- Protect the confidentiality of PHI to the fullest extent prescribed under HIPAA, regardless of whether the organization and its employees all comply with HIPAA, state laws, and the policies and procedures put in place to protect PHI.
- Use PHI only for legitimate purposes as defined under HIPAA or applicable laws.
- Prohibit the use of PHI for discriminatory practices, including those related to insurance coverage or employment decisions.
- Timely notification of individuals if security breaches have compromised the confidentiality of their PHI.
- Work with appropriate law enforcement to prosecute to the maximum extent allowable by law any individual or organization that intentionally misuses PHI.
- Continuously improve processes, procedures, education, and technology so that PHI practices improve over time.

The organizations also renewed their position in favor of a federal preemption of state health care privacy laws. HIPAA allows states to maintain their own health care privacy laws as long as they are more stringent than those in the federal rule. Many states reportedly have laws with tougher health care privacy provisions than HIPAA, particularly in the areas of drug and alcohol abuse, HIV/AIDS, and mental health treatment.

In 2002, California enacted a law requiring people to be notified if their personal information has been compromised by a privacy or security breach, and since then an additional 32 states have passed such laws. HIPAA does not have a notification requirement.

The joint policy position contains a provision that "uniform and universal protections for PHI should apply across all jurisdictions in order to facilitate consistent understanding by those covered by such laws and the individuals whose health information is covered by such laws."

More information is available on-line at http://www.amia.org/informatics/public_policy.asp#confidentiality. ■

HHS issues Privacy Rule decision tool

The Department of Health and Human Services Office of Civil Rights has issued a decision tool for disclosures for emergency preparedness under HIPAA.

The document says emergency preparedness and recovery planners are interested in availability of information they need to serve people in the event of an emergency. For example, planners seek to meet the special needs of the elderly or persons with disabilities in the event of an evacuation.

HIPAA's Privacy Rule permits covered entities to disclose protected health information for a variety of purposes. The Office of Civil Rights says the tool presents avenues of information flow that could apply to emergency preparedness activities.

The rules regarding the use and disclosure of protected health information could apply to all individuals, with no special rules applying to particular populations, such as persons with disabilities.

The Office of Civil Rights says the tool does not address other federal, state, or local confidentiality rules that may apply in specific circumstances. For example, disclosures permitted by the Privacy Rule for public health would generally be prohibited under federal substance abuse confidentiality law. Because the tool focuses on issues relevant to emergency preparedness, the tool does not present all the uses and disclosures permitted by the Privacy Rule, nor does it discuss all the rule's requirements.

To guide planners in determining how the Privacy Rule applies to disclosures for emergency preparedness, the tool focuses on the source of the information being disclosed, to whom the information is being disclosed, and the purpose of the information being disclosed.

More information is available on-line at http://www.hhs.gov/ocr/hipaa/decisiontool. ■

of the Emergency Medical Treatment and Labor Act (EMTALA), according to **Stephen A. Frew,** JD, a risk management specialist and web site publisher (www.medlaw.com).

The jury's Sept. 14 verdict stated that although the cause of death was a heart attack, the woman also died "as a result of gross deviations from the standard of care that a reasonable person would have exercised in this situation."

The woman's daughter, who was with her mother in the ED waiting room of Vista Medical Center East in Waukegan, IL, had previously complained that her mother had waited too long to get care.

A deputy coroner testified at the hearing that he subpoenaed hospital records after noticing discrepancies in the hospital's version of events after the woman arrived at the ED at 10:15 p.m. July 28.

The daughter told investigators her mother, Beatrice Vance, had complained of chest pains and the two drove to the hospital, about a mile north of their home. According to hospital records, the woman was seen by a triage nurse at 10:28 p.m., and complained of nausea, shortness of breath, and chest pain at a level she rated as "10" on a pain scale. The triage nurse reportedly classified the patient's condition as "semi-emergent."

The daughter said she twice asked nurses when her mother would see a doctor and first was told she was next on the list to be called, and the second time was told that two ambulances had just arrived with more urgent cases.

At 12:25 a.m., an ED nurse went to the waiting room and called for the woman but got no response, the jury was told. The woman was leaning on her side on a waiting room seat, unconscious and without a pulse.

Physicians rushed her into the treatment area and administered CPR, the jury was told, and at 12:55 a.m. they detected a weak pulse. Ten minutes later it stopped and they restarted CPR. The woman was pronounced dead at 2 a.m. An autopsy showed she died of a heart attack caused by blockage of an artery in her heart.

The jury was advised of standards from the American Heart Association that showed the woman's symptoms fit the description of a heart attack "pretty much to a T."

The jury also considered medical guidelines that recommend patients apparently suffering from a heart attack should be put on cardiac monitoring immediately and have an electrocardiogram done within 10 minutes of arrival at the hospital.

Neither measure was taken while Vance was waiting, according to the coroner. He also testified that professional organizations recommend that blood thinners and other medications be administered within three hours of arrival, but in this case, no medication was given until after the heart stopped.

In his comments on the case, Frew noted that the coroner's jury went out of their way to send a message regarding ED delays and indifference to patient care to this hospital and all hospitals.

"It appears that the public is saying that ED delays are going to come back to bite hospitals," he suggests.

The following factors make it likely the incident would be considered as a potential EMTALA violation, Frew says.

1. In all probability, the patient would be classified in hospital protocols as the type who would be taken back to the treatment area immediately. Therefore, a triage error likely occurred, which in and of itself is typically cited.

2. Assuming, however, that the triage protocol actually permitted this management of the patient, the Centers for Medicare & Medicaid Services (CMS) is likely to cite the protocol as a violation of EMTALA.

3. Even if CMS could be convinced that the patient was properly sent to the waiting area, the reassessment requirements of EMTALA clearly indicate that a delay of two hours without reassessing a chest pain patient would not be likely to escape citation.

Pregnant woman has potential EMTALA claim

A pregnant woman who came to an emergency department (ED) and was told to wait while staff determined if an on-call obstetrician would see her has a potential claim against an Alabama hospital under EMTALA, according to another recent court decision.

Ginger Henderson alleges that she was 38 weeks pregnant when she was involved in an auto accident and began to experience contractions. The opinion by the U.S. District Court for the Middle District of Alabama states that she contacted her personal physician, who advised her to go to the nearest hospital ED.

The complaint alleges that Henderson presented to a clerk at the ED at Medical Center Enterprise (MCE) in Enterprise, AL, and said that she was pregnant, had been in an auto accident, and was experiencing contractions two minutes apart. She was directed to the waiting area, the

complaint continues, and later was summoned back to the desk and told she would have to wait while staff contacted the on-call obstetrician and determined whether he would see her, since she was not a regular OB patient at the hospital.

The woman left and sought treatment elsewhere.

The court found that the hospital policy was that OB patients over 20 weeks' estimated gestation should be evaluated by the ED physician prior to being sent to the OB area. There is no indication of triage or a physician medical screening exam, according to the opinion.

"A jury could find that Mrs. Henderson was treated differently from other patients presenting with the same symptoms because her obstetrician did not practice at MCE," the judge ruled. "This difference in treatment not based upon a difference in symptoms would violate MCE's obligation under EMTALA to provide appropriate medical screening."

The court also found that "a jury could conclude that having to wait for the OB physician on call to decide whether or not Mrs. Henderson could be treated unreasonably delayed screening or treatment."

The hospital maintained that the patient's departure was a voluntary withdrawal of her request for treatment. The court ruled, however, it was for the jury to decide whether the departure was voluntary or induced by the hospital's actions, and whether the hospital complied with EMTALA requirements for obtaining a signed informed consent to refuse care before Henderson's departure.

It is not clear whether the hospital was inspected by CMS over the incident or whether it had been cited for EMTALA violations, Frew points out in his analysis of the case. "The allegations in the complaint would appear to be of the level and type that would be cited if CMS found the facts matched Henderson's version," he adds.

Although it appears that Henderson did not suffer physical harm, the court ruled that emotional distress could support a verdict under Alabama law.

EMTALA law suits can only be brought by a patient or another hospital that has suffered a legal loss or harm from a violation, Frew notes, but CMS citations may be issued without any allegation that any harm resulted from a violation.

The next step is for the case to go through pretrial procedures, he says, and for a jury to decide whether Henderson can prove the facts as alleged, and what damages, if any, will be awarded. ■

Technology, staffing head conference topics

Capturing signature can be challenge

Technology advancements, patient identification concerns, and staff turnover were among the hot topics at the 2006 conference of the North Carolina Association of Healthcare Access Management (NCAHAM) in Asheville, NC, says president-elect **Charlynne Lynch**, CAM, manager, financial counseling and emergency department (ED) registration at Wake Forest University Baptist Medical Center in Winston-Salem.

The technology discussion centered on the following tools, adds Lynch.

• **Intelligent, guided registration.**

A template, based on the hospital's rules, placed on top of the registration pathways guides registrars through the process, she says. "It's less generic and more specific. If [the registration] is missing some vital information, it will ask for that."

In effect, this software takes the place of the myriad of "sticky notes on how to handle situations" that registrars put around their computer screens, Lynch adds. "If you get to the point that you're filling out an accident screen, for example, it prompts you with, 'Is there liability? Was this a car accident?'"

• **Electronic signatures.**

"A lot of hospitals have a challenge in capturing a signature for the general consent form," she says. "Sometimes the nurse participates in that process, and sometimes it's left up to access."

In some cases, Lynch adds, the piece of paper with the signature might not end up with the medical record.

However, with a portable device with a notebook-size screen, similar to those used by the UPS she says, registrars can conveniently capture patient signatures as needed, including at the patient's bedside or in the emergency department (ED) treatment area.

One of the issues involved in obtaining consent signatures is that many patients, such as direct admits, don't go through the normal admission process, Lynch notes. "It's a challenge for patient access staff to be at every portal of entry to complete that registration."

• **Address verification.**

The access department frequently gets com-

plaints from the back end about bills that are returned because access personnel didn't capture the proper patient address, perhaps depending on an outdated one in the system or on a patient's driver's license, notes **Keith Weatherman,** CAM, MHA, associate director of patient financial services at Wake Forest Baptist and a past president of NCAHAM.

Address verification software does searches, not just with the U.S. Postal Service, but of the person's recent financial transactions, such as the payment of a telephone bill, that show the most current address, he says. "Technology is available that allows [the registrar] to prompt an address search during the registration process."

At present, Weatherman adds, his hospital is using this type of service in a batch mode. "If there is a questionable address and we put in an address indicator, it will trigger this file."

Another hot topic at the conference was the ongoing problem of staff turnover, Weatherman notes. "People want to know what others are doing in that area."

"The goal in registration is to 'get it right the first time,'" says Lynch, "but how do you equip staff members to be able to do that?"

"When you do get good employees, how do you hang onto them?" adds Weatherman. "You lose them to 9-to-5 jobs, and better-paying back end jobs." **(See related story, this page.)**

State certification available

Also at the NCAHAM conference, Lynch notes, the organization's state certification examination was offered, and was taken by seven access professionals.

The exam, Weatherman explains, was established in the mid-'80s as an alternative to the more expensive national access certification exam offered by the National Association of Healthcare Access Management (NAHAM).

Since that time, he says, a number of North Carolina hospitals have made the certified access manager (CAM) credential a requirement for certain positions.

At Wake Forest Baptist, for example, those who hold manager or assistant manager positions in access areas must have the certification, Weatherman says.

(Editor's note: Charlynne Lynch can be reached at chlynch@wfubmc.edu. Keith Weatherman can be reached at kweather@wfubmc.edu.) ■

Access turnover still most challenging issue

There's hope, veteran director says

Staff turnover in the access field takes a heavy financial toll on health care organizations, notes **Keith Weatherman,** CAM, MHA, associate director of patient financial services at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

"It takes time for human resources and management to review applications, interview, test, check references, hire, and train new staff," says Weatherman, who is in the process of writing a white paper on the subject. "It takes time for the new registrar to get up to speed to do the work at the accuracy level that is needed."

The cost of mistakes in registration resulting from that lack of experience and full understanding of the job is significant, he adds, in an environment in which denial management is an ongoing challenge.

It is not uncommon for access jobs to remain open for three or four months before being filled, Weatherman says, and it takes at least another three months before a registrar is working at the desired competency level.

During that six-month period the work has not stopped, Weatherman points out, so someone has to fill the vacancy — registering patients in the admissions area or the ED and doing it within the required timeframe to ensure proper patient care.

That usually requires overtime, he says, which is not only expensive but often results in burnout on the part of the registrars who have to work harder and more staff turnover down the road.

"Before we can determine fixes for staff turnover," Weatherman says, "we must understand the reasons behind it." Among those, he lists:

1. Registrar is usually considered an entry-level position, which means it is low on the payroll scale compared to other jobs in patient finance.

2. The hours are not conducive to "normal" family life. Only a choice few have the luxury of working a first shift, Monday through Friday position. Twenty-four hour coverage often means pulling staff from one shift to another and using part-time employees who get few, if any, benefits.

3. Opportunities for promotion within patient access are rare. When employees are seasoned

and want more money or better hours, they transfer out.

4. Most patient finance jobs, including accounting, collecting, billing, and verification, are Monday through Friday positions, so access staff often leave the "front end" for these "back end" positions. They no longer have to work holidays, either, and there is usually a pay increase involved.

5. Patient access employees are considered "critical staff," meaning they must find a way to and from work when there is inclement weather. Yet because they are not clinical staff, the organizational "Snow Plan" for offering transportation often does not include them.

While many studies have indicated that the No. 1 reason employees leave their jobs is because of problems with supervisors or co-workers, Weatherman notes, his almost 30 years of experience in the industry tells him that is not the case with patient access staff.

"It has been my observation that most access managers understand the importance of keeping well-trained staff and are constantly rewarding them and showing appreciation," he adds.

So, is solving the problem of patient access turnover a lost cause? Not so, says Weatherman, who offers the following list of remedies:

1. Stay in touch. Visit the staff, know the staff, and understand their jobs and their barriers. Do what it takes to eliminate those barriers. Make sure your "off shifts" have access to required information. Even better, have a leader available to them for consult.

2. Make the human resources staff aware of the importance of the job roles in patient access.

3. Be creative in developing different schedules or time tracks.

4. Develop a career ladder for patient access staff. Give employees an opportunity for promotion, so they don't have to leave the department.

5. Consider bonus pay for off-shift, weekend, and holiday work. Provide extra compensation for working during inclement weather.

6. Provide flexible training — training that fits the employees' schedules, not the trainer's.

7. Have flexible and frequent staff meetings that don't require staff to come in on their days off.

8. Stay abreast of and utilize newer technology that helps staff work smarter, not harder.

9. Constantly supply employees with feedback to let them know if they are performing up to expectations. Don't wait for the annual review.

10. Pay employees for their worth. Understand that their job is one of the most important in health care, and that it is cheaper to pay them well and keep them on the job than to constantly fill vacancies and have inexperienced staff on duty.

The front-line access position has changed dramatically since he entered the field in 1977, Weatherman notes. He recalls that the most frequently requested capital item in the '70s was a typewriter, and three decades later it's a personal computer, printer, or software.

"There are new challenges, such as obtaining information before a patient arrives so upstream and downstream processes can happen," he adds. "Insurance contracts require precertification, patients are responsible for higher deductibles and co-pays, yet as a satisfier we want to have patients report directly to a ready bed or service area and bypass the registration process."

Technological advancements, such as real-time address and insurance verification, have helped obtain patient information, Weatherman notes, but are signs of just how complex the registration role has become.

"Technology has enabled our registrars to work smarter, but the pressure of working in a highly emotional, fast-paced environment has not changed," he says. "The job remains stressful, the willingness to work off shifts is still not there."

What also remains true in this decade, Weatherman adds, as was the case in the '70s, '80s, and '90s, is that the chief concern for access management is staff turnover. ■

Consulting firms an option if you can stand the travel

Chargemaster experience desired

For an access professional who doesn't mind packing for extended stays and spending a lot of time in airports, there could be a lucrative job waiting in the consulting field, says **Tom Bennett,** a director with Intech Summit Group, a San Diego-based retained search firm that specializes in health care and does most of its business in professional services.

"We focus on very specific [needs], and we periodically talk with people in a hospital or health care system who have been there for many years," Bennett adds. "Many consulting companies won't consider them. On the other hand, there are clients

who are open to recruiting people from industry."

The primary reason consulting firms often rule out industry candidates, he says, is concern about whether the person could get used to the amount of travel involved.

"Even though we explain that it will require 85% or 90% of time [away from home]," Bennett adds, people initially think they can handle it but find out later they can't.

In addition, consulting firms are "very specific in their requirements and have high expectations relative to a person's background," he says. Typically, that means someone who has a master's degree and is fairly well known in the field, Bennett explains, as opposed to "someone who has sat at a desk and worked and nobody knows who they are."

"Many times people who have been in one organization all their life are kind of limited in the exposure they have dealing with a variety of personalities," he notes.

As for the kinds of experience being sought by these firms, Bennett says, someone who has worked with a chargemaster within the revenue cycle function is particularly desirable. "I hear [often], 'We want somebody with a chargemaster background.'"

"I'm also seeing more people [placed] who have revenue cycle strategy and information technology strategy backgrounds, as well as a strategy and operations background," he adds.

The salary for an access professional coming from a hospital background and known to be good at what he or she does could range from $70,000 to more than $200,000, Bennett says.

"It depends on the person — there are a lot of gradations," he adds. "If you've been at a hospital in the revenue cycle for eight or nine years, a realistic range is $110,000 to $160,000.

"[Consulting firms] want people who are able to look at the revenue cycle and see how it fits within the whole hospital system," Bennett says. "They need to be able to look at the organization and where it stands today, define where it wants to be, and then build a strategy."

[Editor's note: Tom Bennett can be reached at (858) 964-4602 or by e-mail at tbennett@isgsearch.com.] ■

NEWS BRIEFS

MN first state to offer hospital prices on-line

A new web site from the Minnesota Hospital Association (MHA) will enable consumers in the state to access price information on common procedures performed by hospitals in their communities.

Minnesota Hospital Price Check (www.mnhospitalpricecheck.org), which marks the first effort to share state hospital price information publicly, will offer data on the 50 most common inpatient stays (DRGs) and the 25 most common same-day procedures (CPTs).

A 2005 state law supported by the state's hospitals called for the release of data via a public web site by Oct. 1.

Prices listed on the site do not include charges by hospital physicians or specialists, who often bill hospital patients separately. MHA cautioned that the listed prices will frequently be different from a patient's out-of-pocket expenses, and urged patients to contact their insurance companies or their hospital's billing offices for an estimate of what they will pay. ■

24 states pass bills on HIE initiatives

Twenty-four U.S. states passed bills this year or last that called for using health information technology to improve health and health care, and 10 governors passed similar executive orders, according to a recent survey by the eHealth Initiative.

COMING IN FUTURE MONTHS

- ED staff take on inpatient role
- More technology hot topics
- Access regulatory update
- Inpatient preservice collection
- 'Turnstile ED' improves throughput

Among 165 health information exchange (HIE) initiatives identified by the 2006 survey of state, regional, and local initiatives, 45 were in the implementation stage, while 26 were fully operational.

Factors driving those efforts included "improving quality" (92%), "improving safety" (82%), "inefficiencies experienced by providers who need information to support patient care" (70%), and "rising health care costs" (56%).

More than eight in 10 initiatives enabled access to data by physician practices. While the primary source of funding for HIE continues to be the federal government, a growing number of initiatives are deriving funds for ongoing operations from users of their services, including hospitals (24%), payers (21%), physician practices (16%), and laboratories (13%). ▼

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Hospital Access Management	1 0 7 9 - 0 3 6 5	10/01/06
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$199.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Lila Moore, same as above

Managing Editor *(Name and Complete Mailing Address)*
Jill Robbins, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700 Washington, D.C. 20006

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Hospital Access Management
14. Issue Date for Circulation Data Below: September 2006

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			879	910
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	668	688
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	3	3
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	6	4
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			677	695
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	10	13
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			25	25
f. Total Free Distribution *(Sum of 15d and 15e)*			35	38
g. Total Distribution *(Sum of 15c and 15f)*			712	733
h. Copies Not Distributed			166	177
i. Total *(Sum of 15g, and h.*			879	910
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			95	95

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2006 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda L. Mooney Publisher — Date: 9/27/06

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

2006 SALARY SURVEY RESULTS

Hospital Access Management™

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

Access professionals are getting their due as front-end expertise more often sought for top-level positions

Silos continue to disappear 'in all aspects of the revenue cycle'

Long gone are the days when access services took a back seat to the business office or patient accounting. At least when it comes to director-level positions, industry sources tell ***Hospital Access Management,*** access expertise is highly sought after and valued by health care organizations seeking to shore up their revenue cycle teams.

"It's one of the better [fields] to be in," says **Carolyn Milburn,** president of Milburn Partners Inc., an executive search firm that specializes specifically in revenue cycle positions. "You have more options to take your career to different areas because [access knowledge] is so needed."

Milburn's firm is working to fill a divisional revenue cycle director position for a national hospital chain, she adds, and "the target is that the candidate comes with strong access experience in order to complement the other people in divisional roles."

"This is a major for-profit system with 48 hospitals, and [leadership wants] a person to be the access expert to the business office or revenue people on the team," Milburn explains. "While they're not calling it an access specialist, that [function] has been strongly emphasized in the organization."

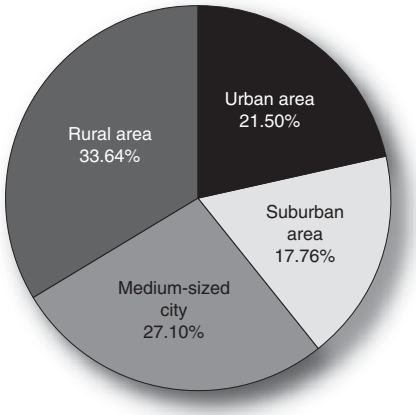
Typically, someone with only business office experience would have been hired for a divisional position, she adds, "but they want someone strong on access who may have touched the back end, because they need that expertise."

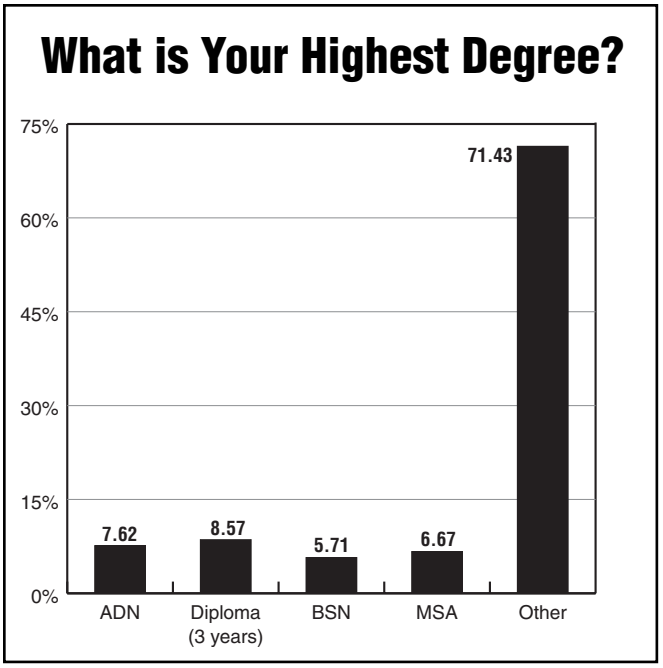
The person ultimately hired for the position will be a peer to others on the revenue cycle team, she says, and a salary of $125,000 is being offered.

Strong customer service skills, among other things, set access professionals apart from their colleagues in other parts of the revenue cycle, Milburn says.

"Many of these organizations are opening hospitals to be like hotels, so they're looking for that high-energy personality," she adds, as well as financial acumen. "That's a hard combination to find.

Where is Your Facility Located?

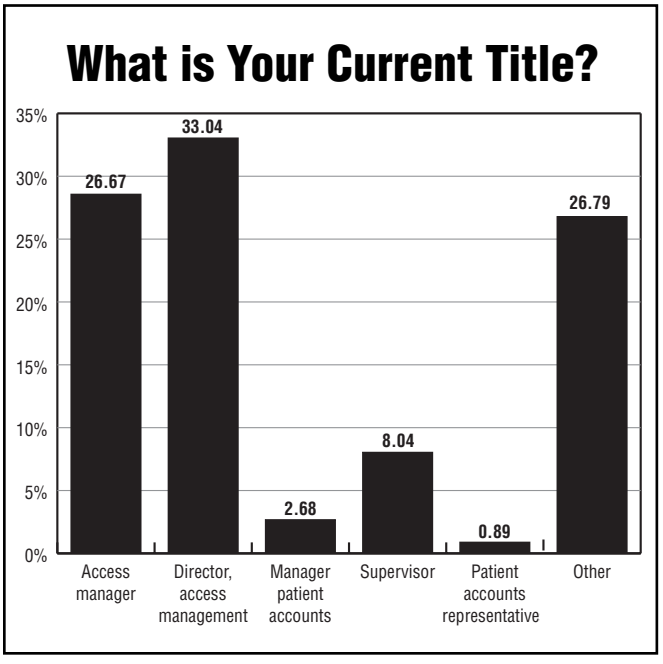




"The back-end [managers are] used to going through numbers and finding the errors," Milburn notes. "The front-end people are more social and want to be more involved in processes. In my opinion, they're better at accepting change."

One job candidate Milburn has worked with completed an administrative fellowship in health care and has a strong customer service background and training experience, she says. "He is now targeting the access services field for his career because of his customer service focus. He's thinking that area needs attention."

Her firm recently placed a person at the director level, with access responsibility for the hospital service line, at a large nonprofit health system with an academic medical environment, Milburn says. The system, located in the Southeast, includes five hospitals and 21 physician clinics, she adds. Because of the complexity of the position, Milburn notes, the director level there is comparable to a regional role in other health care organizations.



The salary was $150,000, which drew an, "Oh, my gosh" from the system's chief executive officer and chief operating officer, Milburn recalls. "I think that [figure] was getting close to their level."

A similar position at that system, which is located in the Southeast, has responsibility for outpatient access and scheduling, with a salary of $125,000, she says.

Specialized access skills, such as experience with a call center, can make a candidate particularly attractive, Milburn points out.

"We've worked on a lot of call center positions," she says. "A gentleman in Atlanta, who was highly regarded, was hired as director of a call center at $90,000, and we placed another call center director at $82,000."

Both individuals had just two to three years' call center experience, preceded by the same amount of time in accounts receivable, Milburn notes, but the combination of the two areas was a big draw.

Based on data compiled by her firm from a group of 148 professionals with director-level experience in access services, she says, those with one to three years' experience have an average salary of $69,500, while for those with four-plus years of experience the average figure is $83,800.

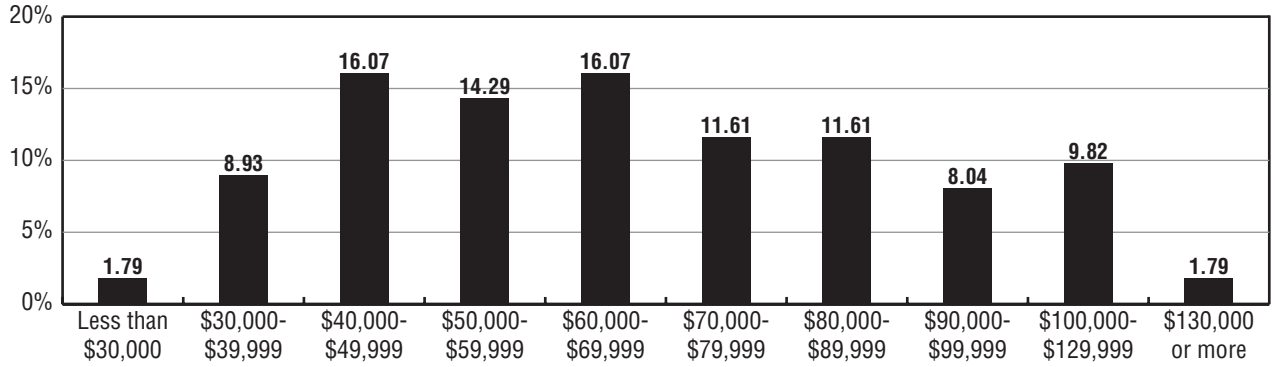
Salaries for access managers, meanwhile, average $60,000 with one to three years' experience, and $73,300 for four-plus years of experience, adds Milburn. The candidate pool used, she notes, consists of individuals employed by nonprofit and for-profit hospital systems across the country.

Breaking down the figures according to region and profit status, Milburn says, her data indicate salaries are higher in the Northeast and the West, compared to other regions of the country, and at for-profit systems.

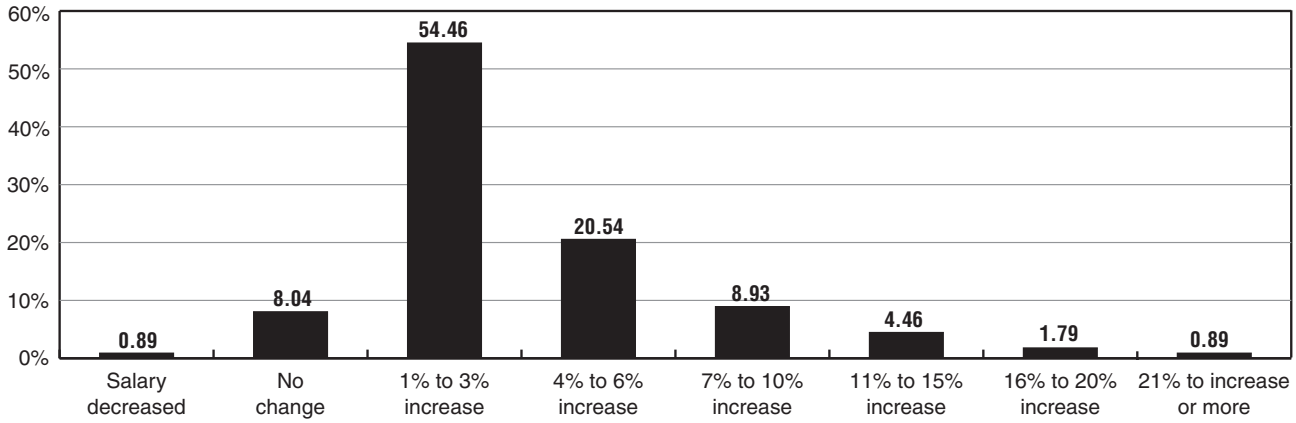
Higher salaries 'an investment'

Silos are disappearing in patient access, patient accounting, and medical records — all aspects of the revenue cycle, notes **Vickers Chambless,** with Vickers Chambless Managed Search in Atlanta. "That trend has been going on for a while, and it's more and more pronounced this year."

What is Your Annual Gross Income from Your Primary Position?



In the Last Year, How Has Your Salary Changed?



Meanwhile, salaries are up for director- and vice president-level revenue cycle posts in competitive hospitals, Chambless says. "Salaries for [those positions] are increasing because that's where the increase in hospital revenue is. It's an investment, having people who are better at that.

"Well-informed providers," he adds, "recognize that they are competing for revenue cycle talent whether they are located in towns of 300,000 or in metropolitan Los Angeles."

Those who aren't as well informed will catch on eventually, Chambless says. "I still get calls from hospitals with less competitive salary ranges, that don't have an awareness of what's going on. If I say [they should offer] $10,000 to $12,000 more, they need independent verification. Usually that verification is when one of their employees is recruited away."

Chambless says he recently spoke to a vice president of revenue cycle who told him that if the chief financial officer would accept his recommendation on an initiative that would cost $22,000, there would be a return of $750,000 a month.

"What will happen if that CFO doesn't accept is that well-informed employee will leave," he adds.

Salaries at the manager level are static now, but that could change, Chambless says. "In 2007, there will be fewer facilities with a less competitive outlook because they can't attract people and people will be stolen from them. And the next year, in my opinion, there will be fewer still."

Those seeking advancement in the revenue cycle arena, on the other hand, "have got to be able to relate to the person senior to them," Chambless advises, "and that becomes an accountant. An access manager or director may not report [directly] to a CFO, but maybe to a revenue

cycle VP who reports to a CFO. So ultimately they are reporting to an accountant."

With that in mind, he suggests pursuing business or accounting degrees rather than liberal arts. Those are best earned in the conventional way — not on-line, Chambless adds.

Those who, like in the example above, are arguing for progressive initiatives, should consider becoming involved with professional organizations, he says. "Attending conferences, like [those offered by] the Healthcare Financial Management Association, makes you better able to lobby to get the things you need. It gives you more ammunition to argue with."

Survey breakdown

Access professionals responding to *Hospital Access Management's* 2006 Salary Survey reported gross incomes that ran the gamut — from $30,000 to $130,000 — with just a percentage or two falling outside either end of that range.

Most respondents (46.5%) said they made somewhere between $40,000 and $69,999, and the next heaviest grouping (23%) fell between $70,000 and $89,999.

About 8% reported incomes of between $90,000 and $99,999, and just under 10% said they made between $100,000 and $129,999. On the other end of the scale, 9% had incomes of between $30,000 and $39,999.

The great majority of survey respondents said their salaries went up in the past year, with most receiving a 1% to 3% increase (54.5%) or 4% to 6% increase (20.5%). Another 9% got a raise of between 7% and 10%, and 8% said there was no change in their compensation.

A few people reported substantial raises, including 4.5% who said they received an increase of between 11% and 15% and just under 2% who got an increase of between 16% and 20%.

The most commonly selected job title — of five choices — was director, access management (33%), followed closely by access manager (28.5%). The next highest number (27%) chose the "other" category and listed a variety of similar, access-related titles.

Those included titles that were virtually the same as the stated categories, such as patient access director; director of registration; manager, patient access services; access & staffing manager; registration & scheduling manager; and admitting manager.

Also listed in the "other" category were some titles that suggested broader or different responsibilities, such as patient financial services director; business office manager; director of patient accounting; director, health information management/patient access; and senior director, access services/chief privacy officer.

A few respondents gave their title as revenue cycle director, reflecting an apparent industry trend toward a more comprehensive approach to patient finance.

Asked to give their highest academic degree, 8.5% of respondents chose "diploma (3-year)," 7.6% selected ADN, 6.7% selected MSA, and 5.7% chose BSN.

More than 70%, however, chose the "other" category, and mentioned a variety of degrees, including a few MBAs and other master's degrees, and several bachelor's degrees. For about a fourth of that 70% of respondents, a high school diploma was the highest degree obtained.

As usual, the vast majority of respondents work for hospitals (93.4%) and "non-profit" (87%) best describes the ownership of their employer. A little more than 6% work for a for-profit organization, less than 1% said they were employed by a college or university, and 5.45% work for state, county or city government.

More respondents said they work in facilities in rural areas (33.6%) than in medium-sized cities (27%), urban areas (21.5%) or suburban areas (18%).

Most of those taking the 2006 survey, about 66%, were between 46 and 60 years of age, with the heaviest concentration (32%) between ages 46 and 50.

The gender gap continues, according to the latest survey, with women representing 81% of respondents. ■