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'Revenue managers' improve dialogue between physician clinics, billing office

Goal is resolving issues that could result in decreased income

A newly formed team of "revenue managers" is working to link billing and clinical departments, providers, access personnel, and insurance payers and help resolve issues that otherwise could result in decreased income at the University of Arkansas for Medical Sciences (UAMS).

The initiative came out of the timely convergence of feedback from an internal survey and a benchmarking study by the University Hospital Consortium (UHC), says **Beth Wheeler,** director of operations for the UAMS faculty group practice (FGP) billing office.

"We have 21 clinical departments, each of which has a clinical administrator," she adds. "We decided in spring 2005 to survey the Group on Business Affairs [GBA], which is made up of all those administrators, to find out how the billing office was doing."

Part of the feedback from that survey, Wheeler explains, was that administrators wanted more communication between the clinical departments and her office, which does the billing and collections for UAMS physicians and other clinical professionals, such as nurse practitioners and licensed social workers.

About the same time, UHC did its own survey, to benchmark academic billing offices. "They used the data to identify the top 10 performers, and each of the 10 wrote a case study on why they were successful."

Those case studies revealed that several of the hospitals involved had individuals functioning as liaisons between billing offices and clinical departments, Wheeler says.

As the UAMS survey already had identified the need for more communication between those two entities, the solution presented by the UHC study seemed tailor-made, she adds. To begin developing the idea, Wheeler says, the clinical executive GBA — a subset of the clinical administrator GBA made up of six clinical administrators and herself — broke into smaller groups and began contacting individuals at the suc-

cessful UHC facilities to pick their brains.

"We wanted to find out what had worked for them, what hadn't worked, and what they would do if they had it to do over again," she says. "We got job descriptions and all kinds of material. It was very valuable."

The clinical executive GBA put together a proposal and a budget and presented it to the college of medicine, which gave its approval, Wheeler adds. "From the time we did the survey in the spring of 2005, it took about a year to hire the first person."

One of the conclusions reached early on was that the revenue manager initiative was too big to just add on to someone's existing responsibilities, she notes. "We needed an individual to be in charge of this program."

That person turned out to be Nicki Morris, whose title is assistant director of operations for the FGP billing office. "Her function is to get the program up and running and maintain it, to be the key person in hiring personnel. We felt that we had done the outline, but we wanted someone to get in there and work on the details."

Start small, get it right

With a strategy of "start small and get it right," the decision was made to hire three revenue managers to work with three of the 21 departments, she says. "We decided to use those represented by the [administrators] in the executive GBA group — medicine, pathology and obstetrics-gynecology."

One of the expectations for the revenue managers, notes Morris, is that they will work closely with the Revenue Integrity Specialist Team (RIST), which is the primary resource for access personnel at UAMS, to identify obstacles at registration. **(See article on RIST in the October 2005 issue of *Hospital Access Management.)***

While RIST members focus on resolving front-end issues that can interfere with the ability to get paid, revenue managers will look at problems that occur on the back end, after the billing process has been initiated, she says. "We're all here to generate revenue and make money for the physicians and the hospital."

The goal of the revenue managers, Morris adds, "is to communicate areas that need improvement, whether on the billing side or on the physician side in the clinics."

One example of how her staff will work with RIST, she says, has to do with VoiCert, an automated, telephonic tool that combines multiple pre-certification requests into one phone call and provides documentation of authorization history, Hiryak adds.

As revenue managers began meeting with the clinical departments being targeted in the initial phase of the program, Morris says, "we noticed that a lot of their denials are because the patient isn't really eligible because of an identification or name mismatch."

"We started asking whether they verify insurance when the patient walks in the door, and they said no," she adds. While VoiCert has been rolled out to the clinics, employees are not using it, Morris says. "They said it's kind of cumbersome and made various excuses, such as not having time."

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Editorial Questions

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

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

Revenue managers are getting a demonstration of the product from the RIST team to determine whether, in fact, it can be used efficiently in the clinics, she says.

"We also can go back [to RIST] and say, 'This clinic has a high rate of denials due to registration issues. Can you work with them?'"

RIST members do periodic audits in the clinics, Morris points out, "but what they audit may not catch some things we might catch from looking on the back end after the billing process has been initiated."

Dealing with denials

"We look at all the denials and the denial reasons — lack of preauthorization, or a patient not being eligible for that insurance because of a name or number mismatch," she adds. "Say the name [on the account] is Betty Smith, but it really should be Betty Z. Smith."

Two people from the physician billing office at Massachusetts General Hospital — which had "incredible results" with a similar program — spent a couple of days meeting with UAMS revenue managers, billing office directors, and the chief operating officer, as well as the GBA and the clinical executive GBA, Wheeler says. The senior manager for the professional billing office of Mass General's physician organization gave the kickoff presentation for the UAMS program.

In addition, she says, Morris visited Mass General to get a feel for its program.

One of the successes attributed to a Mass General billing manager, as that facility's revenue manager counterparts are known, had to do with a CPT code for which Blue Cross Blue Shield had a technical but no professional component, Wheeler notes.

The billing manager met with a Blue Cross representative, she says, and made a convincing argument that there was in fact a significant professional component to the procedure. The payer is now reimbursing a physician component for that charge nationwide, Wheeler adds.

Revenue manager program service standards

Mission

Facilitate communication between the clinical departments and FGP billing with the goal of maximizing clinical income.

Service standards:

Client services

- Ensure that the highest level of service is provided to all our customers/clients
- Facilitate the resolution of any revenue cycle issues
- Communicate billing office and payer updates
- Meet with physicians, practice administrators, and practice staff to provide financial reporting and operational feedback

Meeting protocol

- Monthly/quarterly meeting with the targeted practices
- Provide an agenda with the meeting documents
- Use a standardized format for minutes and e-mail minutes to the attendees after each meeting
- Develop and maintain a standardized action plan/issues log for each practice
- Develop a standardized work schedule for the revenue managers
  Week 1: report review
  Week 2: denial review
  Week 3: meetings
  Week 4: miscellaneous

Financial reporting

- Presentation of the "standard reports"
- Charge & collection data
- A/R information
- Adjustment report
- Denial report
- Presentation of customized reports
- Analyze reports to identify areas of opportunities, incorporating them into an action plan

Denial analysis

- Review denials on a monthly basis
- Analyze trends and try to effect change

Accounts receivable (AR) management

- Research payer policies and reimbursements
- Work with clinical departments on specialty-specific billing guidelines
- Identify payer policy issues that result in denied or improperly paid claims

Program gaining visibility

At UAMS, the assistant director and all three revenue managers spent four days in each of the three departments being targeted by the program, she says. "They all went [to each of the areas] because they wanted to see what was being done the same way and what was being done differently, [thinking], 'Maybe I can translate that to my department.'

"Now they are visible, people know their faces and names, so they're ready to start digging in," Wheeler says. "I'm not sure at this point at what rate we will roll out [to the remaining departments]. We want to make sure as many wrinkles are ironed out as possible."

Before the revenue manager position was created, Wheeler was the point person for questions that came from all 21 clinical departments, she notes. Having the revenue managers in place will allow more time to work proactively on billing issues, rather than simply responding to problems, Wheeler adds.

"Usually when they call it's because collections are down, or they're getting a lot of denials, so we want to concentrate on that," she says. "There are also [concerns about] coding issues and charge capture: Are people actually billing for all the services provided? So [revenue managers] will look at encounter forms, billing documents."

A recent e-mail from the cardiology department had to do with a diagnostic test with a particular code that one carrier is always denying, Wheeler adds. "We feel we can convince [the carrier] that it should be paid."

Her personal take on the mission of her department is that it's about "the three Cs — collections, communication, and confidence."

"We're a centralized billing office, we're off campus, so most of the people that work out here billing and collecting the physicians' money are invisible to them," Wheeler points out. "[Physicians] take care of patients, mark a box on a form, and then don't know what happens to it, but they have lots of questions."

Many of the providers think like they did when they were in private practice, when they knew exactly what they received for each patient and which insurer was paying what, she says. "A lot of them miss that.

"We send reports back to the departments, but they may or may not filter down to the individual providers," Wheeler adds. "If they do, the [physician] may not have time to look at them, or know how to interpret them."

In an effort to fill in those gaps, the reporting function will be a big part of the new program, she says. "[Revenue managers] will take data to the departments and the administrators and will sit down with them at regular monthly meetings.

"They will explain things and identify problems before they become enormous," Wheeler says. "We're revamping the entire reporting structure so we can do a good job of making it understandable."

Much of the inspiration for that has come from the leadership at Massachusetts General, where an "unacceptable" collection rate has been replaced by "spectacular results," she notes. "The chief operating officer told me, 'We used to provide data, now we provide information.'"

Drawing from material provided by that organization, her office has developed a list of service standards for revenue managers. **(See list, p. 27.)**

"We have a fairly standardized schedule that each [revenue manager] can follow," Wheeler explains. "We want the departments to feel that they are getting a consistent level of service: [For example], this week the revenue manager is in the office working on reports, this week she is making presentations, this week she is trouble-shooting."

That kind of arrangement was recommended by several of the billing offices that have successful programs, she adds.

To get a realistic look at the programs at other facilities, Wheeler says, the clinical executive GBA group made it a point to talk with the person in her position, with a department administrator, and with an actual revenue manager.

"We wanted to get a full picture, not a skewed [perspective]," she says. "One thing we heard fairly consistently is 70-30: About 70% of the time the revenue managers are all doing the same thing, and about 30% of the time they're doing things that are unique to that department."

Of the three revenue managers, two came from the billing office, and the other had been a billing manager for a clinical department, Wheeler says. "We felt our first [hires] should have a strong background in the billing area."

That differs from the approach at Massachusetts General, she notes, which has been to look first for people who can think on their feet and have great communication skills, with the idea that they can be trained for the billing-specific duties.

"If you do that, you have to have a great training program," Wheeler points out. "Since we are brand new, we didn't want to start with employees who don't know what we do."

(Editor's note: Beth Wheeler may be reached at WheelerElizabethL@uams.edu. Nicki Morris may be reached at nmmorris@uams.edu.) ■

State goes extra mile with new charity policy

'It's more inclusive than the norm'

All the community hospitals in the state of Washington are voluntarily expanding their financial assistance guidelines in what is being described as one of the more far-reaching policies of its kind in the United States.

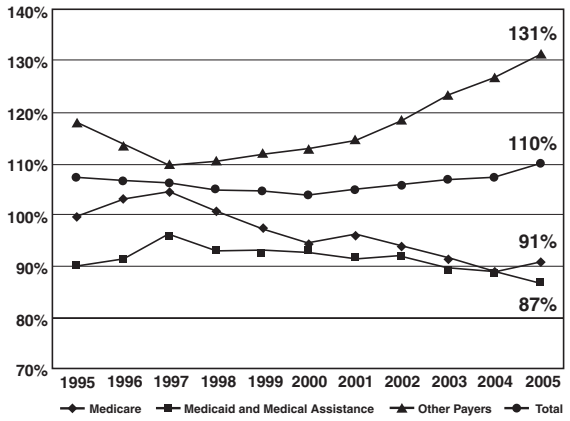
"It's fairly comprehensive — more inclusive than the norm," says **Cassie Sauer,** MSW, vice president of communications for the Washington State Hospital Association (WSHA) in Seattle. "We didn't do extensive research, but that is the indication from conversations [with colleagues] in other states."

The new guidelines ensure that the low- and moderate-income uninsured are charged a moderate fee for their care, she adds. "At most, they are charged what a typical insured patient would be charged."

Patients who fall within 300% of the federal poverty guidelines, meaning those with an income of up to $60,000 a year for a family of four, qualify for the program, Sauer says. "We didn't go above that amount because we do believe that above that income level people can afford to purchase insurance and not having it is more of a choice."

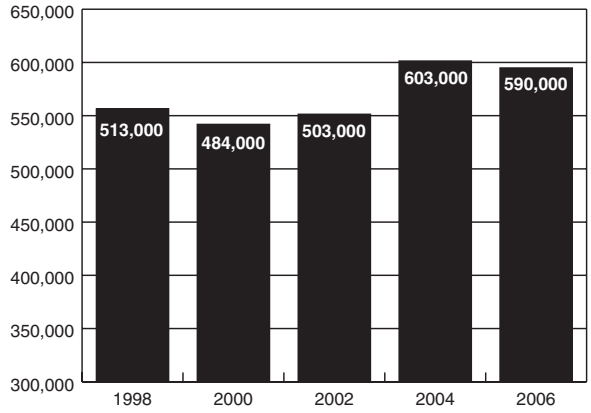
That conclusion is supported by a Robert Wood Johnson study indicating that about 20% of those who are without insurance actually could afford to buy it, she adds.

Percent of costs paid by various payers



Source: Washington State Hospital Association

Number of uninsured under 65, 1998-2006
Washington State



Source: Washington State Hospital Association

The American Hospital Association is featuring the Washington state program as a leadership model, Sauer notes.

Another goal of the program is to better inform patients of available assistance, she says. "Some hospitals provide charity care, but do patients even know about it? What are the standards in place to make sure they know it exists?"

With that in mind, the policy states that hospitals must provide more information to that effect, Sauer says. "Every patient will receive written notice about financial assistance, either at check-in, upon discharge, or with the bill."

The highlights of the new policy, which provides three levels of discounts depending on the patient's income level, are as follows.

• Patients whose income is between zero and 100% of the federal poverty level ($20,000 for a family of four) receive free care.

• Uninsured patients whose income is between 100% and 200% of the federal poverty level ($40,000 for a family of four) will be given a discount. The discount is calculated so that, on average, the most these patients will be asked to pay is the cost of care at that hospital.

• Uninsured patients with limited assets who are at between 200% and 300% of the federal poverty level ($60,000 for a family of four) also qualify for a discount. The discount is calculated so that, on average, these patients are asked to pay what an insured patient may pay, even though the uninsured have no one negotiating on their behalf.

Commercial insurers typically negotiate a discounted rate because they drive volume and referrals to the hospital, Sauer notes.

One of the key provisions of the policy specifies that hospital boards will increase their oversight of

collection policies, she explains. "Every year, [boards] should receive a report on what collections actions were taken on behalf of each hospital."

In addition, hospitals will establish clear and consistent procedures that must be followed before accounts can be sent to a collection agency, Sauer says. The idea, she adds, is to eliminate instances in which, for example, one financial counselor sets up a payment plan for a patient while another sends an identical account to collections.

Part of the impetus for the new policy was a bill proposed in last year's state legislative session that would have expanded financial assistance requirements "beyond what we thought reasonable."

The proposed legislation "was overly burdensome and would have put a lot more regulations on hospitals," Sauer adds.

Although the bill did not pass, the state hospital association responded by assuring legislators that it would address the issues that it deemed reasonable, she says.

"A lot of times, the initial bill is good but then they start adding this and that," Sauer points out. "We told [legislators] we would work to address their main concerns."

Those concerns centered around whether the uninsured were being charged a fair price or given the very highest bill, whether people were being informed about the availability of financial help, and whether collection practices were fair, she says.

Over-the-top collections practices — such as a $10,000 bill turning into a $100,000 bill because of interest charges or people being arrested or losing their homes — were not identified as a problem with the hospitals that WSHA represents, Sauer says, but the association highlighted the issue as a preventive strategy.

Choice easier for some than others

While CEOs at all the community hospitals have signed the financial assistance pledge, she notes, some did so more readily than others. **(See pledge, p. 30.)**

Charity care pledge signed by WA hospitals

All the for-profit, nonprofit, and public district hospitals in the state of Washington have signed the following pledge as part of an initiative aimed at expanding financial assistance guidelines to offer discounts to more residents.

Footnotes to the pledge explain that "uninsured" means no third-party insurance and health savings accounts are considered insurance. They also specify that income for those under 100% of the federal poverty level includes both earned and unearned income but excludes assets; income for those above 100% of the poverty level may include assets.

Finally, cost-to-charge ratios are based on the previous year's year end reports filed with the Washington State Department of Health.

Hospital voluntary effort on billing to the uninsured

These proposals are meant to supplement existing charity care policies and are not intended as a replacement. There are already requirements in law governing notification, collection practices, and sliding scale discounts. These proposed standards would be added to the current requirements. We are also proposing minimum standards for hospitals and anticipate many hospitals will be able to offer broader policies.

Notification (applies to all patients)

• All hospitals will provide a written notice to all patients informing them about the availability of financial assistance.

Collection practices (applies to all patients)

• All hospitals will have their governing board or commissioners receive and review an annual summary report on collection actions taken.

• All hospitals have a written policy as to when and under whose authority an account is sent to collections.

• All hospitals have a written policy as to when a lien is placed on a primary residence.

Discounts (applies to the uninsured for medically necessary inpatient and outpatient services):

• No uninsured patient with income under 100% of the federal poverty level is required to pay for care.

• No uninsured patient with an annual income under 200% of the federal poverty level is required to pay more than the estimated cost of their care. (Cost is the charge multiplied by the hospital's average cost-to-charge ratio.)

• No uninsured patient with an annual income under 300% of the federal poverty level is required to pay more than 130% of the estimated cost of their care. (Cost is the charge multiplied by the hospital's

"Some signed in August and September [2006] and some signed in the middle of December," Sauer says. "We started the effort in May and spent about six months asking them to sign. For some it was an easy choice, and for some it was more challenging."

Hospitals expressed legitimate concerns, she says. "Some were already providing [financial assistance] at this level or close to it, but for some it was a big expansion. In rural areas, 300% [of the federal poverty level] includes almost everyone."

Because all of the hospitals did agree to participate regardless of those concerns, Sauer says, "we pledged to them to go back and let legislators know the impact of this on providers."

Although the legislation referred to above did not pass, Washington is one of a few states that does have a law, enacted in 1990, governing charity care, she points out.

But while other states with charity care laws typically have developed mechanisms to fund the care provided, that has not been the case in her state, Sauer says.

In Washington, the Medicaid program gives only limited funding to a few hospitals that provide a large amount of charity care and small grants to hospitals for a portion of their charity costs, according to a report prepared by the state hospital association. However, the report continues, there is no charity care pool to pay hospitals for all their charity care costs.

The report points out that hospitals often charge more than the cost of care for insured and self-pay patients, and that low government payments are a primary reason for the high charges. **(See charts, p. 29.)** Since government payers do not cover the cost of care, the report continues, the unfunded burden must be shifted to patients with insurance.

(Editor's note: Cassie Sauer can be reached at CassieS@wsha.org.) ■

WA hospitals adjust to meet aid guidelines

Change 'not that big' for some

At Yakima Valley Memorial Hospital in Yakima, WA, the implementation of new state-wide financial assistance guidelines "wasn't really that big of a change," says **John Vornbrock,** FACHE, senior vice president and CFO.

With the focus in the past couple of years on nonprofit hospitals promoting community benefits, including charity care, he adds, "we had been emphasizing that and trying to make charity care applications much more accessible to the public."

The goal at Memorial Hospital is that any patient who is registered for a service but for whom no insurance has been identified is provided with a charity care application, Vornbrock says.

That effort, begun in early 2006, has increased the volume of financial aid applications so much that it has been necessary to add a new staff position, he notes. "We actually have an individual whose full-time job is to go through those applications and ask additional questions to determine [whether patients] meet the criteria."

Despite the additional volume, the overall amount of uncompensated care at the hospital has not increased, but has gone down a bit, Vornbrock says. "The difference has been that a higher percentage of uncompensated care is charity care as opposed to bad debt that goes to collections."

When the state program came along, he adds, "we tweaked our guidelines to go along with that. **[See related article, p. 29.]** The bottom line is that we previously had not offered any charity care [to patients] above 200% of the federal poverty level, but now those between 200% and 300% are included."

While the effect of that category change has not been determined, Vornbrock says, he doesn't expect that difference to be a significant amount.

About two-and-a-half years ago, he notes, Memorial instituted a policy whereby any individuals without insurance were automatically given a 25% discount on hospital charges

"That came at a time when there was a lot of criticism of hospitals that only the uninsured were paying full charges, and then clarification from Medicare [on what constituted] fraud and abuse," Vornbrock says. "It was the first time hospitals ever considered doing anything other than full charges. We had always been told we couldn't do that, that it was a violation."

Implementing the 25% discount "also had a big impact on changing the composition of uncompensated care," he adds, "so [the state program] has not really resulted in more charges being written off. This is a really poor community to begin with."

When the national discussion on charity care heated up, it was not as big a deal in Washington

because of the state's existing statute on charity care, Vornbrock points out.

"[Hospitals] had to comply," he notes. "Some hospitals have actually bumped up their limits. Quite a few are at 400% of the federal poverty level."

More paperwork, more people being helped

When the new financial assistance guidelines were implemented at Grays Harbor Community Hospital in Aberdeen, WA, in early 2007, it meant a dramatic increase in the number of people who are eligible to receive aid, says **Jacquie Shay,** director of patient financial services.

"There's a real satisfaction in the business office because a lot more people in higher income levels qualify," add Shay, who oversees the business office, registration, and medical records. "There's more paperwork, more phone calls, more people asking for assistance as more people become aware that they may qualify. It's very gratifying that we can help them."

Her department hasn't yet increased staffing, but is "feeling burdened," she says. "It's only been a couple of weeks, but it's quite noticeable. It takes a little longer on our end to figure out [who qualifies]. There is a learning curve to learn how to do the task differently."

For her hospital, the new guidelines open up the possibility of financial aid to one category of patients while placing tighter restrictions on another, she explains.

"Up until January, we were providing a 100% write-off [of charges] to people at or below 200% of the federal poverty level," Shay says. "Not everyone was doing 200%, but we were being generous."

That means that before a one-person "family" making $19,000 might have had its entire hospital bill written off, but under the new guidelines would get only 58% written off, she explains.

"Now we are spreading [the help] out, giving it to people who are at up to 300% of the federal poverty level," Shay adds. "A lot of people make a decent wage, but there is not enough money to go around. Now at least they can get a percentage of the bill written off.

"The general consensus is that we support [the new guidelines]," she says. "We are pleased to offer help to those we couldn't help before."

[Editor's note: John Vronbrock can be reached at (509) 575-8003. Jacquie Shay can be reached at JShay@whnet.org.] ■

WA, other states give on-line price, quality data

Various comparisons offered

The latest initiative by the Seattle-based Washington State Hospital Association (WSHA) and its 97 member hospitals is a web site that provides hospital-specific price and quality information.

The site, made public in late January, provides information on hospital-specific charges for more than 500 types of hospital treatments; hospital-specific performance on quality indicators related to treatments for heart attack, heart failure, pneumonia and prevention of infections; and answers to common questions about hospital bills and the availability of charity care and financial assistance. **(See related story, p. 29.)**

The site was created in response to requests from state lawmakers and the public for more hospital-specific data, says the WSHA.

In a similar step, the Arkansas Hospital Association has launched Hospital Consumer Assist (www.hospitalconsumerassist.com), a web site that provides Arkansas residents with information on the average prices that individual hospitals charge Medicare for 25 types of inpatient stays.

The prices are based on claims data from the federal Medicare Provider Analysis and Review tapes, and can be used to help patients gauge how much they might be charged for similar care, the association said. The reports also show how the hospitals compare nationally and statewide on each of the 20 measures developed by the Hospital Quality Alliance and posted on the Centers for Medicare & Medicaid Services Hospital Compare web site.

Prices will differ for each patient, the association cautioned, as discounts may be applied to the price based on negotiated rates with insurance companies or the hospital's discount for the uninsured. It said variation in health plan coverage and discounts also impact patients' out-of-pocket costs.

The Iowa Hospital Association, meanwhile, has unveiled Hospital Pricepoint, a web site that gives free access to data on inpatient charges and services at Iowa facilities.

For each hospital in the state, the web site provides data on average and median inpatient charges for more than 60 diagnoses, and "dis-

count" information for private insurance, Medicare, and Medicaid.

It allows users to compare inpatient charge data for up to four hospitals at once and inpatient charges by severity of illness within a service area. ■

Traditional job recruiting 'not enough,' expert says

Target those who aren't looking

Patient access directors seeking to hire and retain good employees can improve their recruiting ability by looking outside the methods traditionally used by the health care industry, suggests **Jill Schwieters,** executive vice president and leader of the health care group at Pinstripe, a Brookfield, WI-based outsourcing and recruitment services firm.

At the same time the work force is declining and demands on the health care system are increasing, the skills required of patient access representatives have become more complex, Schwieters notes, making recruiting more challenging than ever.

However, the tendency is for hospitals and other health care organizations to try to fill positions the way they always have, she says. "They post jobs and hope people will apply, they put ads in the paper, and they go to job fairs."

These are all good steps to take, but they're not enough, says Schwieters, who recommends what she calls passive recruiting.

"Passive recruiting is a process used to seek out potential applicants that meet a certain professional demographic, competency or educational background," she explains. "Passive candidates may or may not be aware of the new opportunity and may or may not be open to it. Building their interest level in the position is the key objective."

These passive candidates typically are employed individuals not looking for a new job, Schwieters says, and often are approached and introduced to the potential new employer by a recruiter.

Because the position of admitting or patient access rep is not widely known outside the health care industry, she adds, access directors should learn to identify potential candidates who aren't actively looking for jobs but have similar competencies. Those include individuals involved in clerical, computer, or insurance-related activities, Schwieters says.

"Part of it is good investigation," she says. "Partner with [the person doing] the HR function or use a recruitment partner or you can do it through professional organizations. There are computer-related training programs at local universities and Internet postings for a job category with the same competencies."

Instead of a job fair, Schwieters says, "think of another kind of event to profile. Organize a career fair for juniors and seniors in high school and also have other areas of the hospital there, like nursing and rehabilitation.

"Go to the work force development center, where people are really looking for jobs and [access services] is an unknown area," she adds.

To be successful, access directors must look at recruitment as a priority and distinguish the job they're offering from others in the market, she advises. "[Market it as] a fun place to work that cares about employees. What other industry could you work in right after high school and find a good job with benefits, where you are trained on the computer with a high level of technology?"

It's a common practice in health care to use temporary employment agencies to fill job vacancies, Schwieters notes, with the idea of hiring an individual to go "from temp to perm." She cautions, however, that people work for temp agencies for a reason — because they're looking for temporary work.

Access directors should ask themselves, Schwieters says, "whether that temp agency is really screening for the success competencies that you would look for as an employer, and are they really looking toward the long term. You have to look at patterns of longevity.

"You're also paying a premium for that relationship, as opposed to having a structured, proactive approach," she adds. "With a regular screening process, in which you work with HR or a recruitment partner to find [a candidate] who will have a commitment to that role, you move from a short-term solution to more long-term solutions, and you're saving money as well."

Build recruiting 'pipelines'

Something else that is common in health care recruiting — especially when it comes to hiring nurses — is "using an outsource solution vs. out-

sourcing your recruitment," Schwieters says. "Sometimes I worry that we have it backwards in health care.

"My point is that health care, which tends to be slow to outsource, should be outsourcing the recruitment process to get a pipeline of applicants," she adds. "If [health care leaders] try to fill the vacancies themselves, they may not have the resources to be great at it. Why not work with an expert that knows how to source?"

Access directors can develop their own pipelines by building channels with local high schools, technical programs, and colleges and universities, Schwieters says. "Some of the best employees are students. You've got good, reliable talent, even if you only get them for two years. Then you can help them move into other roles in the organization as they complete school."

To help target the kind of individual most suited for an access job, she suggests interviewing existing employees. "Talk to your own staff: 'You've been here five years. What is it that you like about your job?'"

Profile those employees, Schwieters adds. "Are they single, students, moms working part time? What is the demographic for those roles?"

Such conversations also can help when it comes to retaining employees, she points out. "People like to feel appreciated and recognized at work."

(Editor's note: More information on Pinstripe is available at www.pinstripetalent.com.) ■

Hospital CoP changes affect EMTALA compliance

Time, signature issues cited

A one-word change in the Conditions of Participation (CoP) regulations that went into effect Jan. 26, 2007, will make a dramatic difference in compliance requirements for Medicare and EMTALA, says **Stephen A. Frew,** JD, a web site publisher and risk management specialist (www.medlaw.com).

That change, which is "buried deep" within 22 pages of CoP regulations, requires that every entry in the medical record be timed, Frew adds, and it may influence how medical records affect malpractice claims.

"Most risk managers have pushed for timed entries in the medical record to help document sequence and timeliness of care," he notes. "Often EMTALA and other compliance issues hinge on the time of various entries."

Calling time "the new documentation trap," Frew points out that most hospitals that have not gone to electronic medical records have very few timed entries.

The Centers for Medicare & Medicaid Services (CMS) notes in its comments that "the timing of medical record entries is crucial for patient safety and quality of care. Timing applies to all medical record entries, not just to the authentication of verbal orders. This would include orders, progress notes, procedure notes, patient assessments, H&Ps [histories and physicals], etc.

"Timing establishes when an order was given, when an activity, intervention, treatment or procedure occurred, or when an activity, intervention, treatment or procedure is to take place," CMS goes on to state in the final regulations. "Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or timelines of various signs, symptoms or events.

"We proposed minor revisions that would clarify that all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form," the regulations state.

The first applications of the rule likely will occur in EMTALA investigations in the "dedicated emergency departments" of a hospital — the ED or the obstetrics, psychiatric or urgent care areas, Frew says.

The lack of timed entries, he notes, will now be a potential standards level violation for medical records that could turn out to be an EMTALA 21-day Notice of Termination citation.

"On the medical malpractice side," Frew adds, "ambiguities in treatment records caused by lack of timed entries might be fodder for a plaintiff's attack on the record's accuracy."

Risk managers should conduct immediate policy and procedure reviews to assess their facility's exposure, he advises. "Policy changes, staff education, and intense quality auditing will be required in most facilities."

Another change that will impact EMTALA compliance has to do with the new federal standard for verification of verbal orders, Frew says, specifically in the area of phone orders for transfers — including discharges in many obstetrics triage areas — when a physician is not present.

"The current rule indicates that the 'qualified medical provider' [QMP], typically a registered nurse or physician assistant, may effect a transfer and sign the transfer certification after conferring with a physician by phone if no physician is present," he explains. "The rule requires that the physician sign the order after the fact, but no time was specified."

Under another CoP change that went into effect Jan. 26, *all* verbal orders must be verified by an electronic or manual signature within 48 hours unless a state law or rule requires a different length of time, Frew says.

Some states have rules specifying times ranging from 24 hours to 30 days, he adds, and those rules will not be changed by the CMS regulations. States without existing standards will be required to meet the federal standard, Frew adds.

"An interesting twist in the rule is that the actual person giving the verbal order does not have to validate the order," he points out. "Partners, for instance, can sign the order for up to five years. The provision seems to anticipate that electronic systems will be fully in place by 2012."

Frew cautions, however, that the EMTALA rule for co-signature appears to require that the physician actually giving the verbal order for transfer must co-sign the transfer created by the QMP.

"I recommend that the hospital policy continue to require co-signature by the individual physician consulted by the QMP," he adds. ■

CMS offers guidance on HIPAA security rule

The Centers for Medicare & Medicaid Services has released guidance to help organizations comply with HIPAA security standards when they allow remote access to electronic protected health information (EPHI) through portable devices or external systems or hardware.

Entities covered by HIPAA should be "extremely cautious," CMS said, about allowing offsite use of or access to EPHI , and must implement policies and procedures to protect EPHI that is stored on remote or portable devices/media or transmitted over an electronic communications network.

The agency said it may rely on the guidance in determining whether actions by a HIPAA-covered entity are reasonable and appropriate for safeguarding the confidentiality, integrity, and availability of EPHI. ▼

On-line NPI information available through WEDI

Health care providers can receive free on-line information about the National Provider Identifier (NPI) in the form of on-demand audio and video web casts.

The service is being offered by the Workgroup for Electronic Data Interchange (WEDI) and the Blue Cross and Blue Shield Association to help educate providers on how to obtain and implement their NPI by the May 23, 2007, deadline, according to a WEDI statement.

Only about 60% of providers had obtained their NPI by the beginning of 2007, the Centers for Medicare and Medicaid Services estimates. All entities covered by HIPAA, including providers, health plans, and clearinghouses that process health care transactions using HIPAA format, must implement the 10-digit NPI code by the May 23 deadline.

Two 60-minute webcast audio or video sessions are available: one for large practices or institutional providers, and a second version tailored for individual providers or small group practices. The webcasts, which include PowerPoint materials, cover these topics:

- Who Needs an NPI?
- The Application Process
- Obtaining and Sharing NPIs
- NPI and Paper Claim Submitters
- Provider Practice Considerations and Impacts
- Resources and General Questions

In addition to offering the webcasts, WEDI's NPI Outreach Initiative will respond on an ongoing basis to questions submitted via the Q&A feature of the webcast sessions. ■

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