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IN THIS ISSUE

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Registration accuracy driving factor for Baylor's newly implemented EMPI

'It greatly enhances our ability to identify the right patient'

Baylor Health Care has implemented an enterprise master patient index (EMPI) that will allow patients at a dozen hospitals scattered over four counties to be registered more easily and with greater assurance of accurate identification.

"One of the driving factors with the EMPI was to become more patient centered in relationship to knowing who our patients are," says **Mary Best,** corporate director of access services for the Dallas-based system. "We have patients who have been in the Baylor system for many years — at one or multiple facilities — but if they go to a different [Baylor] facility at this point it's like they've never been [in the system] before."

Baylor also is moving toward implementation of a single admission/discharge/transfer (ADT) system, she says, with the first hospital scheduled to go live in July 2007. The full roll-out will take roughly three years, Best adds.

At present there are seven different registration systems among the 12 hospitals, she notes, and none of them are interconnected. "Four are on the same system, but are totally partitioned.

"We want to be more sensitive to patient needs, more focused on service to them," Best says. "We want to have a warehouse of data that will enable us to identify that patient anywhere within the system."

Another driving factor with the EMPI is patient safety, she says. The ultimate goal is to have an electronic medical record (EMR) that will be available to patients' physicians and to other facilities, Best adds. "When the patient presents, [registrars] would not only identify the patient, but have access to the patient's EMR."

The EMPI in place at Baylor "has a very powerful set of algorithms," she notes. "It greatly enhances our ability to identify the right patient and so reduces the possibility of misidentification."

The idea, Best explains, is to prevent two kinds of mistakes from occurring when, for example, a Baylor patient named Jane Smith pre-

sents. One error would be pulling up the wrong Jane Smith, who might have a different blood type. The other would be failing to identify the person as a Baylor patient and so not gaining access to her existing medical record.

The algorithms of the Baylor enterprise system are aggressive enough to "narrow down the field," even with a common name, thereby minimizing the possibility of creating an overlay on the same record, she says. "You can select [parameters] to be as restrictive as you want. You can say it has to match seven of these key data elements or you can broaden that range, or you can have more options from the individual to select from."

At present, the Baylor EMPI is in "passive mode," Best says. "It is not hooked into the registration system and we are not using it for patient identification yet. We have activated and brought up each of the hospitals on the EMPI and each of those is feeding data into it. They are updating the EMPI, whether on existing patients or with new data that are flowing in."

Behind the scenes are the programs it actually will run to identify post-registration duplications, she says. The challenge, and something the Baylor team "worked on quite rigorously," Best explains, is to identify the most complex algorithm that would minimize duplication or misidentification "without creating a nightmare in which everything is going to come up" to be looked at by the registrar.

Typically, there is a hierarchy of data items that will be weighted according to their importance in the process, she says. Patient name and social security number, for example, have greater weight than spouse's name. "The number of data items that have a potential match helps drive the determination as to whether this record is one that might be a duplicate."

Since Baylor is in passive mode with the EMPI for the time being, she notes, "the damage is already done. The patient is already registered and has already received care, but it will notify us of potential duplicates and potential linkages."

Avoidable vs. unavoidable duplications

In the case of potential duplicates, Best says, the account is reviewed and evaluated by access services staff to see if the occurrence was "avoidable" or "unavoidable."

"'Unavoidable' might be someone who comes in comatose, who was picked up on the street with no ID," she says. "There is nothing we could have done to have identified the person correctly."

What access employees focus on are the cases that could have been avoided, Best notes. "It helps to determine what we did wrong, and what we can do to prevent that.

"There are a variety of things to look at," she adds. "A good example would be where someone transposes a number in the Social or didn't enter the birth date correctly. Sometimes there is a handoff from someone who gives the incorrect

(Continued on p. 52)

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Editorial Questions

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Baylor's Standardized Name-Entry Policy

SCOPE:
The scope of this policy is to define requirements for capturing and appropriately identifying patients within Baylor Health Care System.
PURPOSE:
This policy establishes BHCS' position on properly identifying patients within the system and outlines the guidelines for determining what will be considered the patient's name.
POLICY STATEMENT:
It is the policy of BHCS that Access Services staff and other staff responsible for the registration/admission of patients will appropriately identify and capture complete information of patients. Obtaining the name as defined in this policy will help staff properly identify patients within the multiple ADT Systems, EMPI, and PATCOM.

The name for a minor child will be the name appearing on the state-issued birth certificate or Social Security card. Staff will ask the parent to state the patient's given name or the name as it appears on the state-issued birth certificate.

The name for an adult will be the name appearing on the current and valid state-issued driver's license or other state or Federal-issued ID card that is provided as proof of identity. A card issued by the U.S. Citizen & Immigration Services, State-Issued Identification Card or Passport ID form must include a picture.

If the current and valid state-issued driver's license or other state or Federal-issued ID card reflects only the middle initial of the person, staff will ask for the middle name and update the ADT System.

If the current and valid state-issued driver's license or other state or Federal-issued ID card does not reflect a generation name, but the patient states they are a Jr., Sr. etc, the generation should be included in the appropriate name field of the ADT system.

If the current and valid state-issued driver's license or other state or Federal-issued ID card reflects a hyphenated last name, the last name will be listed in the last name field of the ADT system without hyphenation or space.

Patients who present without a valid state-issued driver's license, other state or Federal-issued ID, U.S. Citizen & Immigration Services, or Passport ID will be asked for another form of picture ID. Staff will ask the patient and/or representative for the patient's name as it appears on their driver license, birth certificate or Social Security card if these cards are not available.
RESPONSIBILITIES:
Mary Best - BHCS Director of Access Services
Access Directors/Managers
Clinical Department Directors/Managers with registration over site
DEFINITIONS:

Patient Name. The name of the individual seeking medical attention.
Insured Name. The name of the policy holder.
Guarantor Name. An individual or entity that is financially responsible for the patient account.

PROCEDURES:
Copying Photo ID and Insurance Card
REFERENCES:
None
AUDIT REQUIREMENTS:
Frequency of Audit: Registration Accuracy Audit
Party Responsible for Audit: Director of Access Services or designee
Documentation Requirements: Audit Summary
Audit Results Communication:
Audit Action Steps: Access Directors should be communicating inaccurate entries to the employee and providing the employee with additional training on the importance and how to key the legal name of the patient.

(Continued from p. 50)
spelling on a name. We still consider those avoidable because we need to move further upstream to make sure the name is entered correctly."

One of the things Baylor did as a lead-in to the EMPI project, Best says, was to establish a standardized name-entry policy. "There had been a nebulous policy on how to define the patient's legal name and how to validate it, but we decided to move away from that. We wanted the name to be something we could verify." **(See related story in box.)**

As Baylor moves forward with the implementation of a single ADT system, Best says, it concurrently will be implementing the active mode of the EMPI.

"That will give access services the opportunity

Name-entry policy tightened as lead-in to Baylor EMPI

'Step-down process' outlined

One of the things Baylor Health Care did in preparation for its enterprise master patient index (EMPI) implementation was to establish a standardized name-entry policy, says **Mary Best,** corporate director of access services for the Dallas-based health system.

Moving away from a "nebulous" policy on how to define and validate a patient's legal name, she adds, the organization decided to go with something that could be verified in a concrete way at the point of service.

"We want a state-issued picture ID so registrars can look at the individual and see that it is the right person," Best says, "and are able to confirm, for example, that the first name is Harriet, and the middle name is Jane, and then register the person under that name."

The form of identification might be a current and valid state-issued driver's license or other state or federal-issued ID card, she says. A card issued by the U.S. Citizen & Immigration Services, a state-issued ID card or a passport ID form can be used, but must include a picture, Best adds. **(See Baylor's policy, p. 51.)**

Otherwise, if one Baylor facility registered the patient as Harriet Smith, another registered her as H.J. Smith, and a third registered her under a nickname provided by a friend or family member, "that could lead to misidentification," she says.

The new Baylor policy defines a "step-down process," outlining the steps to be taken when the required form of identification cannot be obtained, Best says. "Ideally, if a patient comes in as John Doe, when he is identified, the [staff] will correct the registration and look for a picture ID."

Both picture ID and insurance cards are scanned as part of the medical record, enabling validation that the individual presenting is correctly identified, she says. "Through the standard naming convention implemented two years ago, ongoing variation in name entry is minimized, reducing the potential for duplication or misidentification in the future.

"In the past," Best adds, "there were concerns about insurance denials or returns if the patient name did not match the name as reflected on the insurance card." That is no longer an issue, she notes, because each registration system now in use enables registrars to enter a patient name, a guarantor name, and an insurance name.

"Under HIPAA electronic billing guidelines, the patient name will be changed to the insured name if the relationship code is 'self,' ensuring the payer's ability to identify the patient without delay," Best explains.

Through the use of the EMPI and the advanced algorithms, long-term patients registered under different names — Bob, Bobby, Robert, for example — are identified and linked both within the same hospital and across hospitals within the health care system, using an enterprise-level MPI number, she says.

"If the patient has been assigned more than one medical record number within the same hospital, the records are merged under one medical record number," Best says. "Since there are multiple registration systems in use at Baylor and each hospital has historically used its own numbering schema, these records are not merged but are linked through the enterprise MPI number." ■

to take advantage of the aggressive algorithms," she adds. "[The system] will come back and give access services the list of potential individuals to avoid that duplication from the beginning, [resulting in] truly improved patient identification and safety."

"We still have work and planning to do, and there are decisions that will need to be made as we start the roll-out process," Best says. "If it is determined that the patient has two medical records, access won't be in a position to merge those two. We will have to have a protocol for which record they choose for the new visit. Some prep work will be needed."

Physician participation in EMPI

One of Baylor's current initiatives is to go ahead and update the master patient index with data from its provider-owned physician practices, she says. "These will be primary care physicians for the most part, so they will have a broad population of patients. Typically, but not always, these patients would go to Baylor for inpatient care."

Pulling in that physician practice information, Best notes, further assures that as people select one of these physicians for primary care, should they need inpatient or outpatient service at Baylor, "we would already have their information, even if they've never been to our hospitals."

In addition to improving customer service, she points out, this will further the ability to feed information into the electronic medical record that is accessible to physician and hospital.

Future plans involve including some of the larger physician groups that practice predominantly with Baylor, Best notes. "As we move forward, if we can work through the electronic upload details, we will begin building their data into our MPI as well.

"One of the things we've heard from patients is, 'Why is it that every time I come I have to go through an extensive registration process?'" she adds. "This is the beginning of minimizing that."

"We will still have to see if there is missing data, and perform the regulatory requirements, but ideally, if you walk in for the first time and the physician is providing uploaded information, at least we will know who you are."

(Editor's note: Mary Best may be reached at marybe@bhcs.com.) ■

ACCESS FEEDBACK

Maine admitting director outlines patient ID concerns

'It's a big problem in the ED'

Like many health care providers across the country, Maine Coast Memorial Hospital in Ellsworth is struggling with the challenge of ensuring accurate identification of patients — especially those who come for treatment in the emergency department, says **Kristen Stiles,** director of admissions for the rural, 64-bed facility.

Stiles says she would like feedback from her counterparts in other hospitals on whether they are dealing with the same problem, and if so, what policies or protocols they have put in place.

In hospitals, the nationwide problem of identity fraud often takes the form of someone who is seeking drugs or has bad credit, she notes. "It's a big problem in the ED, because the person has to be treated and [information] is often taken at face value."

It's not that difficult to know a neighbor's address and give it to the registrar to get treatment, Stiles adds. "We are actively working on it — it's come up over the past year — but it's pretty easy to get a [fake] driver's license or some other form of identification, and you don't have the ability to turn them away."

While getting a handle on the patient identity issue in the ED remains difficult, she says, physicians involved in the treatment of inpatients have become "very proactive."

"If we can't identify the patient, and something is not right, and if the person has been stabilized," Stiles says, "[physicians] will no longer continue a treatment plan."

In one case, hospital personnel have actually called the police department to have a license-plate check run on an inpatient, she adds.

"He had given too many people too many conflicting reports." The man arrived complaining of chest pain and pressure, and while being questioned about his medical history mentioned having surgery in Ireland a few years back, Stiles

recalls. "We couldn't find him under the name he had given, and we couldn't appropriately treat him without a history."

The patient was at the hospital for two nights, she says, "and every time an admissions person went to see him he was sleeping or out of it, but he was very good with the clinical staff."

When hospital staff refused to do any further treatment until they could determine his identity, he said that all of his identification was about three hours away, Stiles says. At that point, she adds, given concerns about proof of insurance and his driver's license, hospital staff told police what had happened.

The registration information on the motorcycle he was driving didn't match any of the names he had given, Stiles says. "We had the police work with us, and his description didn't match what they had on record."

Police didn't share all the information they found on the man, just what was needed to show that he was lying about his identity, she says. Once physicians confronted the man, and he realized he would get nothing more from them, Stiles adds, "he was pretty quick to get better and leave."

"That has probably been our worst case as far as what could happen [with a false patient identity]," she says. "If he had truly had a history of heart problems and had surgery, there would have been different protocols."

The greatest concern, Stiles says, is "the damage we could do to someone who has the wrong [medical] history or if we can't identify and verify, what are we missing from another hospital [which has the patient's records]?"

'Drug-seeking' on increase

Although there is "an explosion of tourists" in the summer, with Bar Harbor just an hour's drive away, for the most part Ellsworth is an area where "you know your neighbors and your [ED] 'frequent flyers,'" she notes. "Drug-seeking is nationwide, and we've had increasing instances of that. Some of [those patients] are pretty crafty."

If the drug seekers use their own names, Stiles says, physicians can note that there's been a history of asking for medication for dental or back pain.

In cases where they can't confirm that there's a drug problem but are suspicious and believe the person might be using a made-up name, she adds, they may give a small amount of medication — "not enough for 10 days, but just a little. Some providers are more and more proactive."

While knowing the population provides "a huge leg up" in recognizing and dealing with patient identity issues, Stiles notes, admissions staff "have a difficult time working with the ED."

"We do the registration piece for the ED, but are not [located] there," she says. "Many of the people in my area have been here for a while, and if [a case] doesn't smell right, doesn't look right, we let [ED staff] know," Stiles adds. "We work closely with them."

(Editor's note: Kristen Stiles can be reached at kstiles@mainehospital.org.

If you have feedback on this or other issues of interest to access managers, please contact editor Lila Moore at lilamoore1@msn.com.) ■

Tool records 'everything related to patient'

'It's great as a training tool'

What began as an automated telephonic tool to streamline the precertification process at the University of Arkansas for Medical Sciences (UAMS) in Little Rock has expanded into a multifaceted system that provides "a communication record for everything related to the patient," says **Holly Hiryak,** RN, CHAM, director of hospital admissions.

"If I'm on the phone talking with a payer about a patient and realize I should be recording the conversation, I click on an icon on the computer and it automatically starts recording," Hiryak notes. "When I complete the call, I can go in and index it so it is easily retrievable."

The tool is "not just for calling insurance companies," adds **Nikki Gray,** a UAMS revenue integrity specialist. "We use it for physician referrals, for calling different physician offices, and for preadmitting patients over the phone."

In the case of employees doing preadmit calls, she says, the system "becomes not just a reference tool, but also a productivity tool."

"We can see how many calls the person made and what kind of transaction it was, and [the information] can be sorted by date, by tracking number, by patient account number," Gray notes. "Whatever information is on the account is pretty much recorded."

One of Gray's duties is to manage activities related to TRACE (Tracking All Communication Events), a product of the Knoxville, TN-based White Stone Group.

"It's a never-ending project," says Hiryak. "We continually implement as they enhance the product." The earlier version of the system was known as VoiCert, she adds, which now describes the product's call management features.

"It's great as a training tool," Hiryak notes. "One of the [access] managers recently overheard an employee speaking inappropriately to a patient, and played back the call for that person, who was cringing the whole time.

"This [employee] is not usually rude, but the patient had been challenging," she explains. Having the recording at hand gave management the ability "to show her she needed to rethink her behavior, and gave the opportunity for her to call the patient back and apologize. It was a quick customer service recovery."

The UAMS transfer team uses the tool to receive transfer requests from outside physicians, many of whom are from other countries and have very strong accents, Hiryak says. "If the transfer team misses something, they can go back and pick up the information they missed or misunderstood and they don't have to keep calling the physician back."

In addition, when arranging a transfer they can refer to the recording to confirm that the type of patient the facility indicated was being sent is in fact what UAMS receives, she notes. If there's an issue, Hiryak says, "they can call back and clarify."

With the call-recording feature, known as PC Call, there is a disclaimer that can be set to play that automatically indicates that the call is being recorded, she says. "Some states require that both parties know, and some don't, so depending on what the requirement is in your state, you can set it as the default, or not."

UAMS recently implemented a feature called FaxCert, whereby users can send, track, retrieve, view, and print faxes and paper documents through the Trace server, Hiryak says, "so we always have a record of our faxes."

"Again, it's about quality, productivity, and information," she adds. "If a payer says, 'I never got your [admit] notification fax,' we have the record. It documents time, date, and image."

The fax machine also can serve as a scanner, Hiryak notes. "If we need to have [a document] in the system as part of account information or an e-mail, we can put the document in, hit a couple of keys coded to the server, and it scans the image into FaxCert. We always have that image, whether a referral or an admit notification, and we can index it to a particular patient."

Another feature, a PC-based application known as PixCert, makes it easy to capture images of entire web pages — such as an on-line eligibility document — or anything received via email or the web, she adds.

Before, when access employees went on-line to check eligibility, they had to manually document or print out the information, which sometimes encompassed multiple pages, Hiryak notes. "Now it can all be captured on the server, so everybody sees what was captured that day, and it saves the person from later having to look it up again."

Overturning denials

The centerpiece of the tool is something called a DCR (Digital Communication Record) Tracker, which allows users to access completed and pending transactions, she says. "It sorts all of our communications — by fax, PixCert, monitored call, etc. We can go into the server and pull them up by patient name, date of service, and other search parameters."

DCR Tracker, she explains, enables the user to:

- play back phone recordings.
- view, print, and route faxes and paper documents.
- view and route electronic documents, web pages, and e-mails.

The end result, Hiryak points out, is that the business office has a single tool to go to for everything involving the front end. "If they're researching a denial or trying to find out what was going on with a patient on a particular date of service, they have that information readily available."

UAMS has had denials overturned because of the precise documentation provided by the TRACE tool, notes Gray, and those positive outcomes can be tracked with a program called Ascent.

"Ascent allows the business office and areas such as admissions or outpatient clinics to communicate information about denials," she explains. "There is a report that lists denied claims, the reasons for the denial, and how much money was denied."

Admissions staff go through the report to iden-

tify the denials for which that department was responsible, Gray says. "For instance, if the claim was denied due to not having a pre-authorization or referral on file, it is counted as an admissions denial."

Employees then look through the notes on the account and determine if the pre-authorization or denial was, in fact, already done, and whether it had a tracking number associated with it from using TRACE, she adds. If so, the admissions department is able to count that as an overturned denial, because there is documented proof (voice or image) that the required work had been done, and the money attached to the account can be recovered.

Since 2005, Gray says, TRACE has been directly responsible for at least 12 denials being overturned, with a dollar value of just more than $410,000.

"We do the overturned denials process once a year," she adds. "[March 2007] was the second time we've done it since we started using the products in 2005."

It's the 'go to' place

"The tool has enhanced the ability of end users to document their findings and record them in a centralized fashion, so there is one 'go to' place for everybody to find that information," Hiryak says. "It's web-based, so they just have to log in."

Depending on the security level that is set, users can access all or part of the functions, Gray says. "'Permissions' are set according to whether you need to see all transactions going through the server, only the ones sent/received by your department, or only the ones you send/receive individually.

"For instance, one of the admissions insurance people sees all faxes going through the server, and she can distribute them to various individuals or groups listed in the Tracker software," she adds. "Of those individuals or groups, some have the ability to see everything sent to that particular group, and some only can see what is specifically sent to them. It depends on your job duties, and what you need or want to see."

Some users are able to amend a call, Gray notes. That means, she adds, that if a voice mail message related to a particular account is recorded on PC Call, the user can attach it to the existing record instead of creating a whole new tracking number.

"If they only use one part of [the tool], like VoiCert, or use it only for certain calls, we can set the security levels accordingly," she says.

The settings can be configured based on location, Hiryak says. "The ENT clinic staff, for example, sees only their ENT transactions."

Other departments don't need to see, for example, internal communications between access and the nursing unit, she notes, "which are recorded in case there is any discrepancy."

Another component of FaxCert has not yet been rolled out, Hiryak says, because of a decision to initially focus more on the access process.

"With FaxCert, you can also receive and send broadcast faxes related to patient transfers," she notes. "Say you're trying to place a patient in a rehab or SNF. You can broadcast-fax the information to notify different facilities that you are looking for a placement.

"If they need clinical information, you can fax that," she adds, "and if a facility calls and says, 'I didn't get page 7,' you can go back in and just send that page."

(Editor's note: Holly Hiryak can be reached at HiryakHollyM@uams.edu. Nikki Gray can be reached at GraySalonicaN@uams.edu.) ■

'Discharge by appointment' taking 'hard-wiring'

'Patients really like it,' director says

A "discharge by appointment" initiative at St. Joseph's Medical Center in Towson, MD, has had some success, but is being challenged by physician delays and families who aren't arriving on time.

"We're finding that some weeks are better than others," says **Jackie Connor**, RN, MS, CCS, director of case management. "We're working now to push up the number of patients scheduled. Our goal is 80% of the patients [in the project] will get a scheduled discharge date and time, but the most we've been able to achieve is about 50%."

Of those with scheduled dates and times of discharge, close to 80% were sent home on time, Connor notes. "We have to keep working with the physicians. The nursing staff is doing a great job, but many times, we are waiting for the physicians to arrive."

In addition, "the nursing staff is trying to be more proactive with patients and families," she says. "Another reason [for delays] is the family

not getting here in a timely manner."

The idea was piloted in 2006 on the hospital's surgical unit and with interventional cardiology patients, and was expanded in early 2007 to include the patients of a large cardiology group and St. Joseph's hospitalists, Connor says. Initially, the project was to have expanded to all patients at that time, she adds.

"We decided just to expand on the cardiology unit, because to do it on seven units — with the follow-up and action planning — would have been very resource-intensive," Connor says.

It also was part of the original plan to identify a date and time of discharge within 24 hours of admission, she says, and there was a concern that the process would get confusing when the cardiology patients were transferred off that unit.

The project parameters were changed, Connor adds, when "we found that we were not successful in identifying candidates for successful discharge within 24 hours because the patient population was too complex."

"Patients came in and were here for a day or two or three being worked up," she explains. "We couldn't make a discharge plan when we didn't even have a primary diagnosis." Until that primary diagnosis and the treatment for it were determined, Connor says, "it was too difficult to determine the discharge date."

In view of that, the decision was made to schedule discharge the day before it occurs, she says. "Every day, the nursing staff and case managers do rounds and identify patients we believe are most likely to be discharged the next day."

The discharge is not actually scheduled until an agreement is reached with the physician, Connor says.

"Some of the processes are automated," she explains. "In order for the scheduled discharge appointment to be recognized by the physician and the ancillary departments, we have to communicate that time. Before the date and time can be put in to the system to alert the physicians and the ancillaries, there has to be agreement between the case manager or nurse and the physician."

Because the information is not entered until that agreement is made, Connor says, "if we see a date and time on the census reports that nurses use, the case management reports, or the physician roster, everybody can be assured" that the plan is set.

A small project team — made up of Connor, the nurse manager and case managers from the unit involved, a physician advisor, and one of the ancillary department managers — meets weekly to review data and decide what action steps to take, she says.

Ten weeks into the project, Connor adds, "we are happy with the results achieved. We believe we've accomplished what a lot of hospitals have not."

Follow-up telephone calls to those whose discharges were scheduled indicate that "patients really like it," she says. "They can plan, and look forward to [the discharge date]. It's all about the planning."

While the process "requires a lot of oversight and hard-wiring," the payoff is worth it, Connor says. "We've decided to continue our focus."

Effort began in 2005

The project has its roots in a discharge task force established in June 2005 as part of a three-year effort aimed at capacity maximization, explains Connor, who was hired in April 2005.

"We had an issue with 'boarders' in the emergency department, and as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80% of the problem should be fixed."

One of the main goals set by the discharge task force was to increase the percentage of patients discharged by noon, she says, but even with that specific intent, several months of data collecting revealed little change.

"The concentrated effort toward getting everyone discharged by noon caused 'bolus' discharges," Connor adds, and then later in the day there would be "bolus" admissions. "There was not an even workload throughout the day."

That's when the decision was made to move to discharge by appointment, she notes.

(Editor's note: Jackie Connor can be reached at jackieconnor@catholichealth.net.) ■

Key to staff retention? Be flexible when you can

'Find the good and shine it up'

Nine years ago, when **Kristen Stiles** became director of admissions at Maine Coast Memorial Hospital in Ellsworth, an access employee who stayed in the job for three months

was considered long term.

Now most of her staff have been around for seven or eight years, Stiles says, and the most recently hired employee has been in the position for two and a half years. That person is actually a "repeat" employee, a former switchboard operator who returned to work in admitting after moving out of state for five years, she adds.

Stiles attributes the longevity of her staff in large part to her willingness to "be flexible on the things you can be flexible on."

Before she became director, she explains, "the people who worked here were like numbers. You plugged a number into the schedule, attached it to a person, and ran from there."

While the system was "very fair and equitable," Stiles notes, the end result of the rigidity was that people tended to leave the job sooner than they otherwise would have because of conflicts with other parts of their lives

In some cases, job performance was not up to par — also because of a mismatch with schedule or work assignment — and the person would be let go, she adds. "The ability to be as flexible as possible has made the greatest difference here."

To whatever extent she can, given the inherent demands of the position, Stiles says, "I make sure the personality is suited to the job they're doing."

Stiles has responsibility for admissions, preregistration, centralized registration, financial counseling, and the switchboard at the rural, 64-bed hospital, and oversees a staff of 13.

"Of the employees I have now, there are more people who came from other areas of the hospital," she notes. "There are only two who are direct hires."

Her staff "like the camaraderie of the area," she says. "It's still a job, and working with the sick public is very challenging, but at the end of the day, I think they like to work in this atmosphere."

"Word gets around" about the congenial work environment, Stiles adds, and she is often approached by people who ask to be contacted "when you have a space" or "when there is availability."

Many of the hires come from housekeeping and dietary services, but she also has gotten employees from the billing department and from physician offices, she notes. "Some are more lateral moves, some are a step up."

Her criteria for hiring, Stiles points out, are more about attitude than expertise

Only one person has joined the department who didn't need a lot of training, she says. "I hire more for personality. You can teach the knowledge, but they need to have the right temperament. They come with skills that can't be taught."

Stiles' secret for keeping employee morale up and staff turnover to a minimum?

"You just have to like people, find the good, and shine it up," she says. "When there are challenges, be supportive and downplay the bad."

(Editor's note: Kristen Stiles can be reached at kstiles@mainehospital.org.) ■

Court decides if EMTALA should apply to inpatients

Issue likely to come up again, says Frew

A 2003 Center for Medicare & Medicaid Services (CMS) regulation that interpreted EMTALA not to apply to inpatients does not have the "force and effect of law," according to a recent decision by a U.S. District Court in Puerto Rico.

The court ruled that a mother could continue with her suit alleging that Hospital San Pablo del Este (HSPE) transferred her newborn child without providing stabilizing care while the infant was in a profoundly unstable condition.

The judicial finding that the regulation is only an interpretation has the potential to bring up the issue on appeal in this or other cases, and perhaps ultimately return the Emergency Medical Treatment and Labor Act to the Supreme Court for further clarification, says **Stephen A. Frew**, JD, a web site publisher and risk management specialist (www.medlaw.com).

The mother gave birth by Caesarean section at the HSPE and the infant originally was taken to the hospital's newborn unit, according to a summary of the case. The child developed emergency conditions, including upper gastrointestinal bleeding, and was vomiting blood, the court opinion stated.

The following day, the physician at HSPE ordered the infant transferred to Hospital Interamericano de Medicina Avanzada, where the child was described on arrival as being "critically

ill." Medical records showed that the infant left HSPE "totally unstable … with active upper gastrointestinal bleeding," the court noted. The child died two days later.

The hospital moved to dismiss the case on the grounds that under the 2003 CMS regulations, it was not bound by the stabilization and transfer rules of EMTALA because the infant was an inpatient.

The court ruled that the 1998 *Lopez-Soto v Jose Hawayek* case had held previously that EMTALA did apply in almost identical circumstances, and emphasized that EMTALA's clear language is not limited to hospital emergency departments. The Lopez-Soto case is the only significant court of appeals case to interpret the Supreme Court ruling on EMTALA in the 1999 *Roberts v Galen* case.

The judge refused to throw out the case because of the CMS interpretation not being binding on the court, and stated that it would not apply in any case because the interpretation was issued after the child's death. The court noted that retroactive applications are not favored by law.

The decision allows the mother to proceed to trial, but she still must prove her allegations and that the conduct did violate EMTALA. Further appeal of the ruling is not likely to be allowed until a final verdict has been rendered in the case, Frew said.

"The original Roberts court clearly felt that EMTALA was not affected by what door the patient entered or what the patient's status in the hospital was, and applied it to an inpatient discharge situation," he notes.

"The interpretation that EMTALA sections are to be read separately is also critical to the building debate over whether the CMS interpretation that 'EMTALA does not apply to inpatients' alters the requirements for hospitals with specialized capabilities to accept transfers under EMTALA," Frew adds.

Specialty units, transfers explained

In other EMTALA-related comments made in answer to a query he received, Frew goes on to emphasize that — despite what some providers assume — whether hospitals have a specialty unit has nothing to do with whether they have to accept EMTALA transfers.

"If you have the specialists or special equipment, you have to accept," he adds. Frew cites a ruling in the *St. Anthony v U.S. Department of Health and Human Services* case, which states in part, "The Act does not define precisely the term 'specialized capabilities or facilities.' Section 1867(g) provides examples of the types of capabilities or facilities that are considered to be specialized: 'burn units, shock trauma units, neonatal intensive care units, or regional referral centers.' But, it neither states nor suggests that such capabilities or facilities are limited to those examples."

The ruling concludes that Congress did not intend the term "specialized capabilities or facilities" to be interpreted narrowly or limited to the examples stated in the act. Rather, it states, the term is intended to encompass those capabilities and facilities that enable a hospital to offer specialized care that is not offered by hospitals that are less well-endowed.

In response to a question Frew received regarding physicians who maintain that "they are the specialists and will decide when, how, and if a patient will be transferred — not the [sending physician]," he says:

"Wrong again. EMTALA rules state that the responsibility for deciding if, when, where, and how belongs to the *sending* physician, because he or she is signing the certification." The receiving hospital and its physicians, Frew continues, can turn down a patient if the following conditions apply:

- The patient is not an EMTALA patient in need of a higher level of care.
- It is a patient-initiated transfer, rather than a transfer for need.
- The hospital lacked the capability or capacity to care for the patient.

Even if it turns out the sending physician was wrong, the receiving hospital or physician likely will still be cited for turning down the request, he adds. "The first physician will just get cited for his errors along with you for yours." ■

JCAHO report addresses language, cultural issues

Hospitals should provide ongoing training to staff on how and when to access language services, The Joint Commission recommends in a recent report.

Other strategies suggested include establishment of a centralized program to coordinate services relating to language and culture and implementation of a uniform framework for systematic collection of data on race, ethnicity, and language.

The recommendations are based on a study of how 60 hospitals are providing health care to culturally and linguistically diverse patient populations.

The most frequently cited challenges related to language and staffing. Hospitals often reported finding it difficult to find staff with cultural or linguistic competency, and some indicated there are challenges created by having a diverse staff.

All but six hospitals reported financial stresses in relation to serving diverse populations. ▼

Study: Access to data not impeded by HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA), which allows states to continue having privacy laws more stringent than the federal standard, has not prevented health care providers from using personal health data to treat patients and enhance health care quality, according to a recent study funded by the Robert Wood Johnson Foundation.

Researchers affiliated with George Washington University School of Public Health and Health Services reviewed federal and state court decisions from 1996 to 2006 involving HIPAA. According to the authors, none of the cases specifically involving questions of conflict between state and federal requirements concerned the denial of a health care provider's access to health information to treat patients, improve quality, or disseminate information for transparency purposes.

The authors say they found no evidence from these legal decisions that more stringent state laws preclude securing necessary data at the point of treatment or including health information in electronic databases used for quality improvement or transparency. ■

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

GAO report: "Much work remains" for HHS' efforts

HHS called into question about progress in ensuring safe electronic exchange of health information

The Government Accountability Office (GAO) says the Department of Health and Human Services (HHS) should define and implement an overall privacy approach identifying milestones for integrating the outcomes of its initiatives, ensuring that key privacy principles are fully addressed, and addressing challenges associated with the nationwide exchange of health information.

HHS disagreed with the recommendation, saying it has established a comprehensive privacy approach and setting milestones would hamper its efforts. GAO reiterated its opinion an overall approach for integrating HHS initiatives has not been fully defined and implemented.

Studies by the Institute of Medicine and other organizations have cautioned that fragmented, disorganized, and inaccessible clinical information adversely affects the quality of health care and compromises patient safety. Also, long-standing problems with medical errors and inefficiencies increase costs for U.S. health care delivery.

GAO says health information technology offers a promising solution to improve patient safety and reduce inefficiencies, with great potential to improve the quality of care, bolster the preparedness of the public health infrastructure, and save money on administrative costs.

"As the use of health IT and electronic information exchange networks expands," the GAO report said, "health information exchange organizations are faced with challenges to ensuring the protection of health information, including understanding and resolving legal and policy issues, ensuring that the minimum information necessary is disclosed only to those entities authorized to request the information, ensuring individuals' rights to request access and amendments to health information, and implementing adequate security measures.

These challenges are expected to become more prevalent as more information is exchanged and as electronic health information exchange expands to a nationwide basis. HHS' current initiatives are intended to address many of these challenges. However, without a clearly defined approach that establishes milestones for integrating its efforts and fully addresses key privacy principles and these challenges, it is likely that HHS' goal to safeguard personal health information as part of its national strategy for health IT will not be met."

GAO calls for more comprehensive effort

HHS officials who commented on a draft of the GAO report referred to the department's "comprehensive and integrated approach for ensuring the privacy and security of health information within nationwide health information exchange." GAO insisted, however, that an overall approach for integrating the department's various privacy-related initiatives has not been fully defined and implemented.

"We acknowledge in our report that HHS has established a specific objective to protect consumer privacy along with two specific strategies for meeting this objective," GAO said. "Our report also acknowledges the key efforts that HHS has initiated to address this objective, and HHS' comments describe these and additional state and federal efforts.

"HHS stated that the department has made significant progress in integrating these efforts. While progress has been made initiating these efforts, much work remains before they are completed and the outcomes of the various efforts are integrated. Thus, we recommended that HHS define and implement a comprehensive policy

approach that includes milestones for integration, identifies the entity responsible for integrating the outcomes of its privacy-related initiatives, addresses key privacy principles, and ensures that challenges are addressed in order to meet the department's objective to protect the privacy of health information exchanged within a nationwide health information network."

HHS objects to GAO finding

In disagreeing with the GAO recommendation, HHS said scripted milestones would impede the agency's processes and preclude stakeholder dialogue on the direction of important policy matters. GAO said its analysts disagree and think that milestones are important for setting targets for implementation and informing stakeholders of HHS' plans and goals for protecting personal health information as part of its efforts to achieve nationwide implementation of health IT.

"Milestones are especially important considering the need for HHS to integrate and coordinate the many deliverables of its numerous ongoing and remaining activities," GAO said. "We agree that it is important for HHS to continue to actively involve both public and private sector health care stakeholders in its processes."

HHS did not comment on the need to identify an entity responsible for integrating the department's privacy-related initiatives, nor did it provide information on any effort to assign responsibility for that activity. HHS neither agreed nor disagreed that its approach should address privacy principles and challenges, but said the department plans to work toward addressing privacy principles in HIPAA and that the GAO report appropriately highlights efforts to address challenges encountered during electronic health information exchange.

70% of Americans concerned about security

The report was released at a Feb. 1 hearing of the Senate Committee on Homeland Security and Governmental Affairs Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia. Subcommittee chairman **Daniel Akaka** (D-HI), said he is deeply concerned about the level of privacy protections in the health IT network, noting a 2005 Harris Interactive survey showing that 70% of Americans were concerned that an electronic medical records system could lead to sensitive medical records being exposed due to weak electronic security.

Federal data breaches cited

"This fear is understandable," he declared. "Over the past few years, we have seen various data mining programs in the federal government that lacked key privacy protections. We also recall the loss of a VA laptop computer and the news of many other federal data breaches that put the personal information of millions of Americans at risk. These incidents reinforce the need to build into any system containing personal information privacy and security protections. Our personal health information must not be subject to these same failings. Privacy and security are critical elements in health IT and should never be an afterthought."

Akaka said that given the overwhelming evidence of the benefits associated with expanded use of health IT, as well as the fact that 70% of Americans are concerned about the privacy of their health information, he was surprised to learn that HHS objects to the GAO recommendations.

"It is clear that the health care industry faces challenges in protecting electronic health information given the varying state laws and policies, the entities not covered by HIPAA, and the need to implement adequate security measures" Akaka said. "But while more and more companies, providers, and carriers move forward with health IT, I fear that privacy suffers while HHS takes more time to decide how to implement privacy protection. HHS must address these issues in a more timely fashion in order to give the private sector guidance on how to move forward with health IT and protect the private health information of all Americans."

University of Louisville School of Medicine Institute for Bioethics, Health Policy, and Law Director **Mark Rothstein**, who also chairs the National Committee on Vital and Health Statistics subcommittee on privacy and confidentiality, told the committee HHS has made "very little meaningful progress" in developing and implementing measures to protect the privacy of health information in electronic health networks.

"Time is of the essence," Rothstein said. "HHS must begin to act immediately on the key privacy issues, and Congress needs to hold HHS accountable... I believe the [GAO] report accurately identifies the great challenges in adopting and integrating a comprehensive and effective strategy to protect public health privacy, confidentiality,

and security as the nation moves to a system of interoperable electronic health record networks."

Rothstein testified that privacy concerns currently lag behind technical development of the Nationwide Health Information Network and the gap is widening as research and development progress while fundamental privacy issues remain largely unexamined and unresolved.

"I cannot emphasize enough how rapidly the field of health information technology is moving," Mr. Rothstein told the committee. "While HHS organizes more task forces and working groups, the private sector is racing ahead to implement a wide array of health information exchanges, medical record banks, regional health information organizations, and personal health record systems. "

He pointed out that several large employers are developing a personal health record system for their employees in hopes of improving employee health and lowering employer health plan costs. Private sector initiatives with personal health records and electronic health records usually are not subject to any federal or state regulation, he said, because they are not covered entities under HIPAA. Also, tens of thousands of other health care providers and health information providers are not covered entities under HIPAA, usually because they are not involved in the process of electronically submitting claims for health services.

Rothstein said he would respectfully recommend that Congress condition continued appropriations for development of the National Health Information Network on HHS demonstrating significant progress in addressing privacy issues. He also recommended that Congress play a greater oversight role on the issue.

As a starting point, he said, HHS should address the 26 recommendations made by the National Committee on Vital and Health Statistics in June 2006. "The first order of business is for HHS to develop a framework for privacy and confidentiality in the National Health Information Network," he said. "Then, the public can participate in the deliberations about the framework. He recommended that HHS

- publish a public request for information about key aspects of the privacy framework;
- hold public hearings around the country on privacy issues;
- fund quantitative and qualitative research on public attitudes toward health information privacy;
- integrate key privacy principles into the National Health Information Network architecture;
- publish an advanced notice of proposed rulemaking dealing with privacy in the National Health Information Network;
- submit a report to Congress identifying gaps in coverage of the HIPAA Privacy Rule and how to address them; and
- initiate public education programs on electronic health records and privacy protections.

Rothstein tells *HIPAA Regulatory Alert* his comments on the GAO report were "more assertive than GAO reports tend to be." Although HHS responded to the report by saying everything is fine, he says, in the weeks following the report there seemed to be an increased interest in privacy at the department.

"Time will tell whether this new level of concern at HHS translates into timely, effective action," he says.

(View the GAO report at www.gao.gov/cgi-bin/getrpt?GAO-07-238. ■

HHS announces flexibility in NPI enforcement

Penalties may be waived

With the May 23, 2007, deadline looming for covered entities to comply with the National Provider Identifier (NPI) rule, the Department of Health and Human Services said it would exercise enforcement discretion and flexibility to give organizations additional time to come into compliance, provided they demonstrate good faith efforts to comply.

"The Centers for Medicare and Medicaid Services recognizes that transactions often require the participation of two covered entities, each of whom is required to comply with HIPAA and that noncompliance by one covered entity may put the second covered entity in a difficult position, the notice said. "CMS also understands that if one of the covered entities is a small health plan, which has a May 23, 2008, compliance date, compliance by the covered trading partner may be especially challenging.

"Therefore, during the 12-month period immediately following the May 23, 2007, compliance date for all covered entities other than small health plans, CMS intends to look at both covered (non-small health plans) entities' good faith efforts to come into compliance with the NPI standards in determining, on a case-by-case basis, whether reasonable cause for the noncompliance

exists and, if so, the extent to which the time for curing the noncompliance should be extended."

The agency said during the 12 months it would not impose penalties on covered entities that deploy contingency plans, to ensure the smooth flow of payments, if they have made "reasonable and diligent efforts" to become compliant and, in the case of health plans that are not small health plans, to facilitate their trading partners' compliance.

"Specifically," the notice said, "as long as a health plan (that is not a small health plan) can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress."

Indications of good faith

The notice gives examples of what CMS will consider as indications of good faith, including increased external testing with trading partners; lack of availability of, or refusal by, a trading partner to test transactions with the covered entity before the compliance date; and for providers to have obtained an NPI and have the ability to use it on HIPAA transactions.

Such contingency plans had been sought by the HIPAA Implementation Working Group, a coalition of health care providers and vendors. The group also had asked CMS to extend the transition period to the national provider identifier by at least 12 months to ensure that implementation not lead to disruption in Medicare payments or services. Members of the HIPAA Implementation Working Group include the American Hospital Association, Laboratory Corporation of America Holdings, and Emdeon Business Services.

In a letter to CMS Administrator **Leslie Norwalk**, the group said full adoption of the NPI requires a three-phase transition: (1) providers must obtain their NPIs; (2) NPIs must be communicated to all trading partners that identify providers in health care transactions; and (3) trading partners must use the NPI in their healthcare transactions.

"The industry has made significant progress on the first phase of NPI adoption," the group said. "We commend CMS for its efforts to assure that providers understand their obligation to obtain NPIs." But the group said the second step was a greater challenge because many in the health care industry had intended to use the National Plan and Provider Enumeration System as their primary source of NPI information during the transition to the NPI, but the lack of access to those data severely slowed industry efforts at NPI communication.

Still waiting on notice from CMS

"Some in the industry have diverted their limited resources for NPI adoption from NPI implementation to sharing NPI information with their trading partners," the letter said. "Others continue to wait on the NPPES data to facilitate their NPI transition process. We urge CMS to release the NPI Data Dissemination Notice as soon as possible and to assure time, robust, and continual access to NPPES data by the provider and vendor communities."

NPI adoption requires a significant transformation in health care communications, the coalition said. It will necessitate the convergence of hundreds of methods for identifying providers to a single enumeration scheme and these efforts are still being developed. Once system upgrades have been implemented and direct testing is possible, trading partners will need time to assure the NPIs work as intended in electronic transactions and to validate that each trading partner's use of an NPI correlates to the same provider and has no unintended effects on transaction processing. "It appears that many in the industry are not prepared for full NPI implementation by May 23, 2007," the group cautioned. ■

New certification combines health care privacy, security

The American Health Information Management Association (AHIMA) is offering a new certification aimed at credentialing the health care privacy and security industry. AHIMA officials said they integrated the Certified in Healthcare Privacy and Certified in Healthcare Security certifications into a Certification in Healthcare Privacy and Security to better serve the industry by issuing a credential that demonstrates mastery in both areas.

Candidates must meet one of these eligibility requirements: (1) bachelor's degree and a minimum of four years' experience in health care management; (2) master's or related degree (JD, MD, PhD) and two years' experience in health care management; or (3) health care information management credential (RHIT, RHIA) with a baccalaureate or higher degree and a minimum of two years' experience in health care management. ■