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Children's facility comes into its own with cutting-edge access center

'It's like having a command center,' manager says

Ever since Monroe Carell Jr. Children's Hospital at Vanderbilt in Nashville, TN, opened more than three years ago, it has been "slowly but surely" establishing its own specialized access services mirroring those at the Vanderbilt University adult facility, says **Tina Williams,** CPC, manager of admitting and emergency registration.

The Children's Hospital opened its own business center right away, and has since moved over its own bed management staff and admitting management, Williams adds. The last service to be moved over is the transfer center, she notes, and the process is culminating with the creation of a distinct access center for the pediatric facility.

"We've created a little bit of a new model, different from the adult hospital," says Williams. At the adult hospital, she explains, "everything is separate." Bed management, the transfer center, the ADT (admission/discharge/transfer) staff, and the administrative coordinator are all in different areas, Williams says, and environmental services dispatch is in the same area as bed management.

At the Children's Hospital's access center, however, all of the functions mentioned above are headquartered in the same big room, she adds. "It's like having a command center in an emergency, but this is 24-7."

As a result, Williams says, "we are able to watch the flow of patients and communicate different issues and opportunities right in the same room, which is different from most hospitals across the country."

From that area, she continues, all the patient throughput stakeholders will be able to view the entire process — from the time a patient is discharged to when a dispatch that the room is dirty is sent to when cleaning starts to when the room is clean.

"We have two flat-screen monitors on the wall — one with the electronic bed board and one with the electronic white board from the emergency department," Williams says.

"We can see what patients are in the queue, what the bed availability is in the house, how many patients are waiting in the ED, and their acuity," she notes. "So we're not only all electronically connected, but now for the communication that requires a phone call, we'll all be in the same room."

The problem the hospital has experienced in the past is that each area involved in the throughput process tends to use its own system, Williams says. "Bed management has always used the bed board, the ED has always used the white board, and we have electronic dispatching for transport and environmental services."

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Editorial Questions

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While each staff could access the other's systems, whether and how often they would do so is another matter, she says. "The bed board and the white board do communicate back and forth to a certain degree, but this will enable all of the experts to sit in the same room and report through the same reporting structure."

All of the players involved already reported to her, Williams says, except for environmental services dispatch, for which she now has responsibility. The only access center employees for which she won't have oversight now are the administrative coordinators, which still report to nursing.

There will be a direct link with Vanderbilt University Medical Center (VUMC) Lifeflight, Williams explains, so that, when requested in the case of patients being picked up by VUMC Lifeflight, the access center can connect to Lifeflight dispatch for simultaneous activation of the transport team.

Those transports, however, will not be dispatched out of the center, she says.

Another big step for Children's Hospital, Williams notes, is the activation — on the same day the access center goes live — of the facility's own 24-7 trauma service, which means the capability to care for all children, regardless of the extent of their injuries or illnesses. **(See related article, p. 87.)**

New space created

To make space for the new access center, two offices — including her own — were vacated, and a wall was knocked down, Williams says. The area was gutted, and seven workstations, with computer ports and other equipment, were installed, she adds.

All calls coming into the access center will be recorded for quality assurance, Williams says.

The workstations are designated as follows, she says:

- two for facility-to-facility transfers;
- two for bed management;
- one for dispatch;
- one for the administrative coordinator;
- one open administrative station.

The access center will provide services such as notifying primary care physicians in real-time when a patient is admitted or discharged, Williams notes.

"This process will be done manually as we work on an automated process scheduled to roll out within the first 90 days of 'go live'"

Pediatric trauma service speeds up access to care

'Better communication' cited

"The common complaint of community hospitals," says **Beth Broering,** RN, MSN, CEN, trauma program manager at Monroe Carell Jr. Children's Hospital at Vanderbilt, "is that [their staff] get passed from one person to the next to the next."

Such occurrences should become virtually nonexistent at Children's Hospital, she adds, with the activation on July 1 of the facility's own 24-7 trauma service.

"When a person calls and says, 'I need to help this child get out of my emergency department because he's very sick and I can't take care of him,'" Broering says, the last thing that caller needs is to be passed around on the telephone.

"They need a very rapid response," she says, "and [the new service] will significantly decrease our response time to these community providers. We will be much more efficient in our ability to respond to their needs."

In the past, Broering notes, the ED and trauma team at the Vanderbilt University adult hospital "would receive and care for and manage" children of all ages who had very critical injuries — including those who were unstable because their blood pressure or vital signs were abnormal — as well as any child who had "penetrating" injuries.

"Children's Hospital has been slowly increasing [its ability] to be able to care for the most critically injured," she says. "Over the past year, we have significantly ramped up our resources so that we will have the capability to care for all children, regardless of what happened to them, what injuries they have, and how sick they are."

The children's facility now has in-house pediatric trauma surgeons and an operating room with anesthesia coverage available 24 hours a day, Broering notes.

"We feel this will be very beneficial from a communication and access standpoint," she says. "This means that providers in the community don't have to wonder who to call: For anyone 15 years of age and younger, they call Children's Hospital."

Opening in conjunction with the trauma service is a new access center at the pediatric hospital **(see cover story)** that Broering says will further enhance the facility's relationship with community providers.

Any time a child goes to another hospital first and is then referred to Children's, she notes, providers will use the access center "and will be able to have better communication, improved follow-up, and more continuity. We are really excited about that."

(Editor's note: Beth Broering can be reached at beth.broering@vanderbilt.edu.) ■

The new center also will provide an ED "expect sheet" to let registration and clinical staff know about incoming patients, she says. "Say a physician is called in the middle of the night because Suzie has a 105-degree temperature and he tells the parents to take her to the hospital and that he'll call and let staff know she's coming.

"The old way," Williams explains, "the physician would call the transfer center and get connected to a resident in the ED who would fill out the expect sheet by hand."

As of July 1, access center employees still gave the PCP the option of talking to an ED resident, but they also completed the form and sent it to both the front desk and the ED treatment area, she says.

"The biggest downfall [in the past] was that when the physician connected with the ED resident in the back, he would complete the form, but nobody upfront would see it," Williams says. Registration staff didn't know about the physician's call or the expected patient.

Call ahead scheduling

Now the greeter or registrar will be able to confirm with the arriving patients and family members that their physician has called ahead, she adds. "The paperwork will also go to the triage nurse, who is the first clinical person the patient will see."

Staff can greet the patient with, "Oh, yes, we're expecting you." It makes the patient feel like, "Oh, my physician did what he said he would do."

In the past, it wouldn't be apparent to patient and family that the physician had called until they got to the treatment area, Williams notes. "We're hoping that this will be a big community physician pleaser."

Soon the new process will be further enhanced

and the information will be sent electronically, she notes. "We have created an electronic expect sheet that will pop up on the white board to indicate the pending arrival of a patient.

"In the top right corner of the electronic white board, there will be the abbreviation 'exp' and a number indicating the number of expected patients," Williams explains. On the left side, she adds, there will be a list of names that staff can click on to display the actual sheet for the individual patients who are expected

One of the intentions with the new center, Williams says, "is that we will always provide our physicians with a live person who can assist them with access to our hospital."

Call volume is so high that under the old process, she adds, "if we can't answer in the transfer center, it rolls over to bed management, and if there is no answer there, it goes to an answering service. Children's will no longer have that rollover to the answering service."

Community physician liaison

In preparation for the opening of the new access center, Williams says, "a community physician liaison met with a large organization of physician practices that serve the hospital to explain exactly what is happening."

The idea, she adds, was "to actually give the visualization that the switch will flip and we will have specialized services within Children's Hospital. We are educating and reiterating to our physicians in-house and in the community that this is actually a place now, as well as a phone number, and what services will be available."

For the sake of continuity, the telephone number that in the past would roll over to bed management will be used for the access center, Williams says, but it will now be "for all of access. It will [reach] whatever you want.

"One of our physicians with a direct admit will get bed management, and if it's a facility-to-facility transfer from a small town, [that caller] will get the person needed to do that," she explains. Someone wanting to send a patient to the ED for evaluation will get the right person, Williams adds. "The only thing we won't handle will be transfers from the scene of an accident or emergency."

Staff at the adult transfer center have been — and will continue to be — "extremely helpful" in ensuring that customers' needs are met, she notes.

The biggest challenge will be getting the telephone number for the new pediatric access center ([615] 936-4444) out to callers accustomed to calling the number of the adult transfer center and then being transferred, Williams says. "We hope that because this will be such easy access and they won't reach a recording or be rolled over to an answering service, that they will want to use the access center number."

Either way, no customer will be told that they need to call another number, she emphasizes. "If you call the wrong number, we will still take care of your call."

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

'eClipboards' smooth check-in for outpatients

'Patients love it,' director says

Having patients use "eClipboards" to review and update their own information during check-in at the Breast Health Center at University Medical Center of Princeton (NJ) is increasing registration accuracy and streamlining work flow, says **Laurie Grey,** director of revenue cycle management.

Patient satisfaction surveys at the center — which opened in December 2006 — are eliciting "nothing but wonderful comments" regarding the check-in process, Grey adds. "Patients love it."

Individuals arriving for a service at the Breast Health Center, she explains, are met by a greeter, who hands them an eClipboard, one of three MediKiosk models created by Maitland, FL-based Galvanon. There are plans to use desktop and freestanding models in future implementations, Grey notes.

Patients take the eClipboard to a seat and use the stylus to go through the registration steps after typing in their last name, date of birth, and zip code to access the proper account.

Typically, access would be gained by swiping a driver's license, Grey says, but in New Jersey driver's licenses do not have magnetic strips.

When the account is accessed, she says, a message comes up, welcoming the patient and asking, for example, if today's visit is for a mammogram. After the patient checks "yes," there is a series of screens asking the person to confirm demographic, physician, insurance, and

other information.

"If it all looks OK, the patient just hits 'next,'" Grey adds. "If at any point the patient needs help, is confused, or has a question, [he or she] clicks on the 'help' button."

There is a monitoring tool, she says, whereby the access associate is able — behind the scenes — to see where the patient is in the process.

"When they say they need help, whatever screen they're on changes to a different color," Grey explains. "[The associate] can say, 'I see you're having trouble with your insurance information. How can we help you?'"

If the insurance information needs to be changed, she notes, hospital management may or may not want the patient to be able to update those changes in the system. Either way, the software can be programmed accordingly, Grey says. "We, the facility, have the option to see if we want the change made by the patient to automatically update or to be reviewed by the patient access associate before updating."

If there is an insurance change, access associates are prompted — also by a color change — to ask for a copy of the insurance card when the patient brings back the eClipboard, she adds.

Putting patients in control

The MediKiosk process — enabled by a Quadramed ADT (admission/discharge/transfer) system and Affinity software — is "very flexible, very user-friendly, and seamless for the patient," Grey says. "There is a minimal learning curve. Ninety-nine percent of the patients totally embraced this. It's such a success, we plan to implement it throughout the organization."

Patients like using the eClipboard, she says, because they enjoy being in control, and recognize the efficiency it adds to the registration process. For staff, Grey says, it has meant less labor at the data entry point, as well as reduced paper costs and management of paper.

With the eClipboard being introduced in a new facility, there is no hard data with which to make comparisons, but it is clear that patient wait times also have been dramatically reduced, she notes. "We can tell by how quickly patients are going through the process. We know that is going to be one of the benefits."

In addition to patient check-in, she points out, the MediKiosk offers other functionalities, such as point-of-service collections and way finding, that the medical center will make use of in the future.

As for how implementation will proceed, Grey says, "we're toying with continuing with patients who are preregistered — in areas such as endoscopy, same-day surgery, interventional radiology and cardiology procedures — and at the same time, looking at walk-in patients, like those who come in for lab draws or chest X-rays."

Which model — eClipboard, desktop or freestanding — is chosen for particular areas, she says, "will be totally dependent on the throughput in [those] departments."

A freestanding MediKiosk, for example, or perhaps a desktop model, might be best for walk-in patients, Grey adds, "because they don't need to see [a staff member] at that point in time. With an eClipboard, somebody still has to hand it out."

As for care and maintenance of the eClipboards, notes **Kathleen Donnelly,** patient access manager, they are housed in rubberized brackets to prevent damage in case they are dropped and are cleaned between customers with sanitary wipes such as those used in patient rooms.

The eClipboard is docked and recharged at night, as well as between patients during the course of the day, Donnelly adds.

Patient flow charted

One of the things the team did in preparation for the eClipboard implementation was to chart the patient flow in the breast health area, Grey says. "We looked at the current process and the new kiosk process to see how things would change. We take so many things for granted — this forced us to take a look at each step and flesh it out."

That exercise helped improve communications between patient access employees and clinicians, adds Donnelly.

"Patient access [staff] knew what we did, and clinical [staff] knew what they did," she explains. The new focus prompted questions such as, "After we give you a call, what do you do?"

What happens now, Grey says, is that clinicians, as well as access employees, are able to monitor the process in the background. When the patient has checked in and is ready for the service, she adds, a technician can take note of that and go out to take the person back to the treatment area.

From the patient's perspective, notes Donnelly, these steps take place seamlessly. Their experience, she says, is, "'I didn't see anybody talking to anybody, but the technician knows I'm ready.'"

"We are really very, very excited about implementing [the kiosk]," adds Grey. "It's becoming

more and more acceptable to have this type of process, where the patient is more in control."

(Editor's note: Laurie Grey can be reached at lgrey@princetonhcs.org. Kathleen Donnelly can be reached at kdonnelly@princetonhcs.org.) ■

Putting nurses in access results in financial gains

'It's easy to show ROI'

Adding six nurses to the central scheduling department has dramatically reduced both denied claims and accounts receivable (AR) days at Delnor Community Hospital in Geneva, IL, says **Karin Podolski,** RN, MSN, MPH, CHAM, director of patient access.

Having nurses check physician orders for completion and take verbal changes for orders over the phone, as well as serve as resources for other access employees, has led to improved relations with physicians and with other hospital departments, Podolski adds.

The program began in 2004, she explains, as a result of multiple complaints from clinical areas based on scheduling quality.

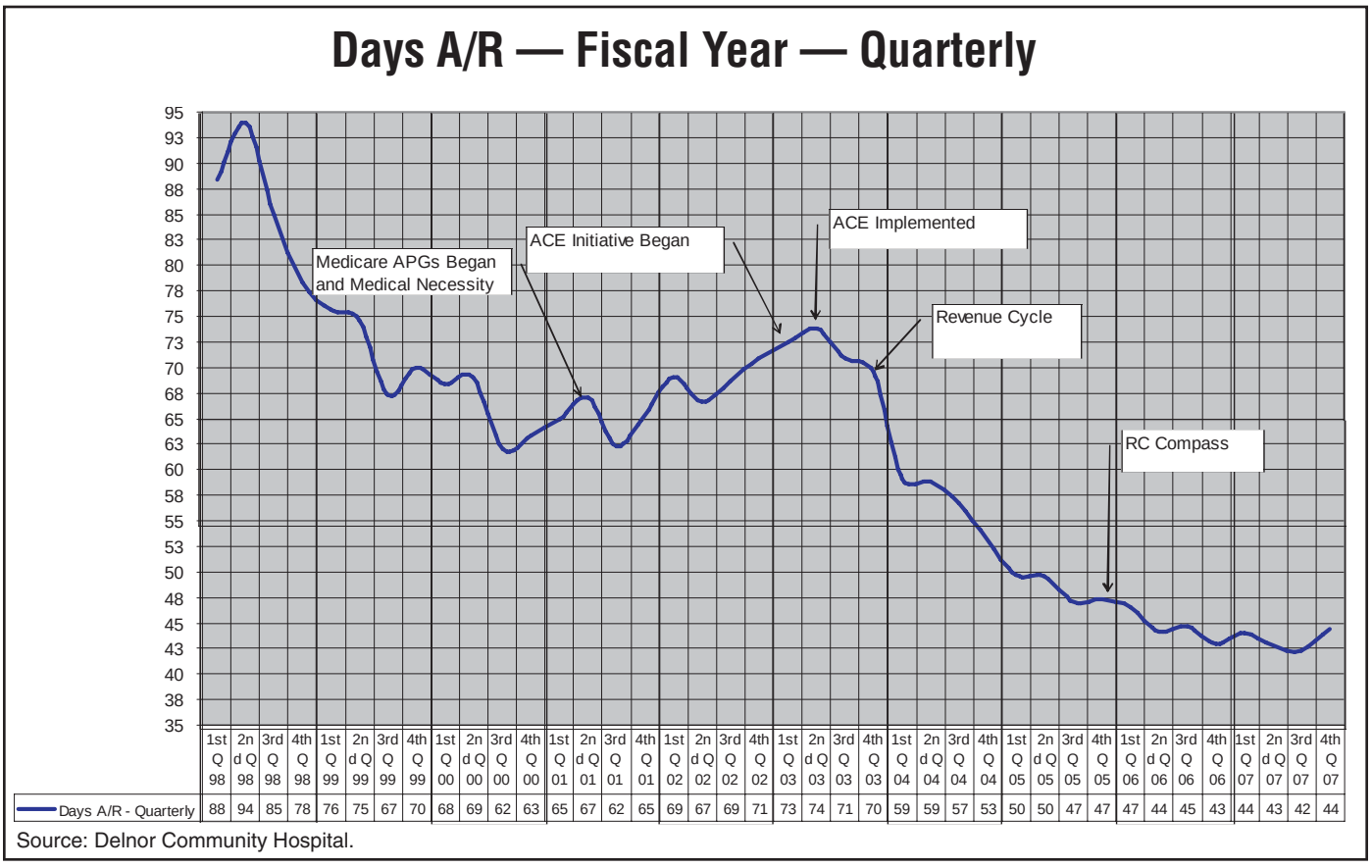
"We would book an exam, and the patient would arrive and it would be the wrong exam, or there would be a problem with the order and we couldn't reach the physician, so we would have to reschedule," Podolski says.

Nurses resource to registrars

Now, when a patient walks in with an order, registrars check it, but nurses are there as a resource, she says. They can amend orders with unacceptable abbreviations — such as an up arrow for increase or HTN for hypertension, Podolski adds.

"We have a lot of illegible orders, and [nurses] can call the physician's office and take the verbal change for the order," she says. "We use them to check Medicare orders for medical necessity. The nurse reviews the patient history to clarify whether the person has a [particular condition], and then can take a verbal amending of the order over the phone."

In the past, patient accounts staff would attempt to contact physicians by fax for further diagnoses, which the physicians didn't like, she adds.



Source: Delnor Community Hospital.

"Say a patient is sick, and calls the physician who is on call on Saturday morning," Podolski says. "If the physician is at home or in the car and wants to send the patient over for an exam, [he or she] can just call [the hospital] and send the patient over with a verbal order."

Nurses trained in coding

Delnor's access nurses were hired from either physician offices or other outpatient settings such as same-day surgery, she notes, and received about two months of training in outpatient coding.

The investment has more than paid off, Podolski says. "We reduced our medical necessity write-off from 10% to 0.6%." During the same period, AR days have gone from the high 70s to 40, she adds. "It's easy to show return on investment." **(See graphs, p. 90, 91.)**

Previously, Podolski says, "there were stacks of orders without diagnoses or that [staff] couldn't read so they couldn't code." Now, the majority of the coding is done on the front end, with some completed on the back end, she adds, but it's all under the purview of the access department.

Medical necessity write-off slashed

The original goal was to reduce the medical necessity write-off from about $11 million to about $3 million, she says, but the figure is now down to about $600,000.

"The only thing we really write off now is from the emergency department," Podolski adds. "It's virtually zero in the other areas. We don't intervene with the ED physicians too much because that's a hard area to address."

If an elderly patient falls, for example, the protocol is typically to do a CAT scan of the head, she says. "We can't really prove they fell and hit their head, often because they are unable to communicate clearly, but [doing the scan] is good medicine."

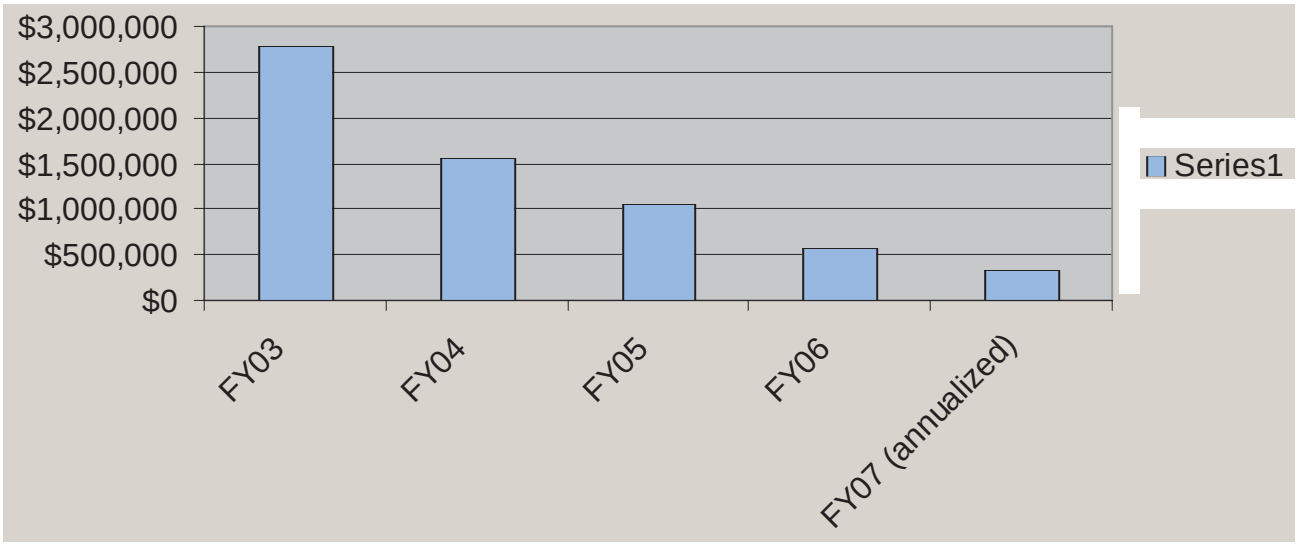
Her own nursing background makes her particularly sensitive to ensuring that the department's nurses are kept "in the nursing loop" within the hospital and the nursing community at large, Podolski says.

"Last year I had them give education to the entire [700-member] hospital nursing staff as part of Spring Nursing Education," she adds. "There were six sessions where they talked about medical necessity, patient orders, and diagnoses. We do get orders from the ED and from the patient floor, so it's valuable to speak to those nurses so they know what is required."

Podolski says she also makes sure that access nurses participate in the Nursing Week celebration each May, and in the shared decision-making opportunities for nurses within the hospital, such as committees on professional practice.

Attracting nurses to access

With hospital nurses typically limited to a 7 a.m. to 3:30 p.m. schedule, or a shift that begins at 11:30 p.m., the more flexible hours offered by the access position make it an attractive option, she



Source: Delnor Community Hospital.

points out. "We have a variety of staggered hours. I let them set their own schedules as long as the department is covered, with a nurse available in both the scheduling and medical necessity areas."

The access department hours are 7:30 a.m. to 6:30 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturday, Podolski says.

When hiring nurses for the access department, Podolski says, she looks for individuals with leadership traits. "They're running the show in problem solving, and they're also a resource for the rest of the access staff who may not be [clinically] trained."

Before registration staff call a physician's office, she adds, "I try to have them filter it through a nurse, so they're not calling all the time."

Having nurses in her department, Podolski says, "has built within the hospital a reputation that we do have resources and we do have credentialed staff within access. If issues arise with clinical areas, they are very responsive when a nurse calls them."

Delnor is a magnet nursing hospital, she notes, and having the nursing component in access has contributed to that process. "It provides opportunities for nursing to grow and expand its role, which is important for magnet credentialing."

As part of their job, the access nurses visit physician offices, Podolski says, to build relationships with physicians and their staffs and to provide them with medical necessity tools. The frequency of the visits varies, but typically are made twice a month, she adds.

"We give them access to software to check medical necessity, and we give them copies of local coverage determinations and updates on regulatory changes, like changes in Medicare guidelines."

(Editor's note: Karin Podolski can be reached at karin.podolski@delnor.com.) ■

Unsatisfactory stay sparks Planetree care model

Nurturing environment valued

One woman's vision of a new type of hospital — sparked after the lack of personalized care she experienced during treatment for a serious illness — resulted in the creation of the Planetree organization, which has become became a leader in pioneering patient-centered care.

Named for the tree that Hippocrates sat under as he taught students in ancient Greece, the organization stresses the value of providing a nurturing environment, in addition to medical expertise and technology, and of listening to what the patient has to say about his or her condition.

The woman behind Planetree — **Angelica Thieriot** — began her efforts in that direction after concluding that the hospital at which she was treated provided good medical care, but didn't address any of her other needs as a human being, explains **Gillian Cappiello,** CHAM, a consultation services specialist for Planetree, which is based in Derby, CT.

Caregivers would talk over her, take her to have tests without telling her what they were doing, and come in and out of her room without familiarizing themselves with her or her chart, Cappiello says. The hospitalizations of Thieriot's father-in-law and son allowed her to experience these communication and education issues from a family member's perspective, she adds.

In the Planetree model that Thieriot's vision helped create, every employee is considered a caregiver — not just the nurse or the therapist, but also the housekeeper and the person talking to the patient about the bill, Cappiello points out.

Much of the focus is on creating a healing environment for patients, families, and visitors — and also for employees, she says. "A lot of what we talk about is care for the caregiver."

There are many applications for access services professionals, notes Cappiello, who previously served as senior director of access services and chief privacy officer at Swedish Covenant Hospital in Chicago.

"From the access side, it's focusing on how you can make your environment more welcoming for the patient," she says. "The human interaction piece is huge, and the physical environment comes into that as well."

Warm colors, comfortable furniture, and soft lighting contribute to a soothing environment, Cappiello points out, as do features that are reminiscent of nature, such as aquariums. She recommends having furniture arranged in conversational groups rather than a row of chairs, she advises.

Removing clutter and reducing noise levels also helps provide a more pleasant experience for patients, Cappiello adds.

Waiting and reception areas should be barrier-

free, she says. "If there's a desk, it should be low, so it doesn't create a barrier between [employee and patient]. Always have somebody there smiling.

"Communication is key," Cappiello says. "Keep patients informed if there are delays." If there is wait time, she suggests, use conveniences such as roaming pagers to give patients more flexibility.

Making wait time more enjoyable

During the wait, she adds, "offer something other than two-year-old magazines." Provide choices for the patient, she adds: "'Do I want to wait here? Do I want to get a cup of coffee?' Have those things easily accessible."

Make the hospital stay more like a hotel stay, Cappiello says, by determining some of the patient's preferences: What newspaper do they want delivered? What is their preference for food service?

Instead of serving meals when it's convenient for hospital staff, she advises, do it when the patient is ready to eat.

CarePages, a program in place at Swedish Covenant Hospital and at several hundred other hospitals throughout the country, is a perfect example of the kind of customer service initiative that Planetree endorses, Cappiello notes. **(See article in the October 2005 issue of *Hospital Access Management.)***

The program allows patients or family members to send updates on the patient's condition over the Internet and receive messages in return, she says. "Families can post photos or write that Uncle Joe had surgery today and is doing fine. It provides a virtual gathering place, a secure web page that is managed by the patient or a family member or friend."

Another way to make the hospital experience easier, says Cappiello, is to provide — starting with preadmission testing — a binder for collecting information regarding the entire process, from testing to follow-up care.

"Have sections for diagnosis, medications, diet, physical exercise or physical limitations, and cards for physicians," she adds. "It's very applicable for people who have a disease that requires [ongoing treatment]."

Having a resource center in a place — possibly in the preadmission area — where it is convenient for patients to go to get information is another way to help them be partners in their own care, Cappiello says.

There are now about 125 hospitals that are Planetree affiliates, Cappiello says, ranging from small rural facilities to large, complex health systems. "The program is not a cookie cutter," she adds. "Every model is going to look a little different."

The Planetree organization gleans ideas and best practices from all the hospitals with which it is affiliated, Cappiello says. "Even with new affiliates, we find things they are doing that are creative and help [other facilities] look at what they might do in a similar fashion."

There is an annual fee for being affiliated with Planetree, she says, and it covers a certain amount of consulting hours — depending on the specific contract — and other resources.

"If a hospital is interested, the chief executive officer would come out and do a presentation for the board of directors and other decision makers," Cappiello says. "Once the facility is signed on, staff like myself would come onsite and do a presentation for all employees, talking about specifics — like a best practice presentation."

An organizational assessment is done — including focus groups with employees and patients — that helps identify the hospital's strengths and where there are opportunities to improve the experience of the patient, she adds. "One of the biggest things hospitals use is patient satisfaction scores and [measurements] of employee satisfaction and staff retention. Typically, Planetree hospitals have much less turnover than the national averages."

Other areas of interest, Cappiello says, are issues of patient safety, such as processes for handling medication errors.

In addition to acute-care hospitals, Planetree encompasses other kinds of facilities, such as long-term care homes and health resource libraries, she notes. The idea behind the libraries — which may be independent or connected with hospitals — is to give patients the opportunity to take some responsibility for their own care by finding out about their medical conditions, Cappiello adds.

Resource for 'cyberchondriacs'

This is a better alternative, she points out, than the popular practice of consulting Internet sites for medical advice and the "cyberchondriacs" that sometimes fosters. "There is so much bad information out there," Cappiello says, that it is helpful to have a librarian and staff to assist with the research.

Access departments often oversee hospital transport, she notes, which offers an opportunity

to enhance the person's initial impression of the facility. Some hospitals, Cappiello adds, pipe music into the parking area and take patients to the front door in golf carts.

Ideally, she says, a hospital "ambassador" is waiting to greet them.

Wayfinding is another area in which the Planetree philosophy can be employed, Cappiello says. "If there are multiple entrances, how do you make sure that patients have the easiest and most relaxing way to get where they're going?

"Signage is horrible in most hospitals," she notes. To make finding the way easier for patients, many Planetree hospitals use visual clues, Cappiello adds. "There might be a water fountain in the corner, or a piece of artwork, and the signage is directed to those things, which transcend language."

[Editor's note: More information on the Planetree organization is available at www.planetree.org or by calling (203) 732-1369.] ■

On-call physician issue frequent EMTALA query

Enforcement varies, expert says

One of the top three questions he gets from health care providers, says web site publisher (www.medlaw.com) and risk management specialist **Stephen Frew,** JD, is also one of the most controversial:

"The on-call physician did not come in and wants the patient sent to the office tomorrow, but then won't see the patient without cash or insurance. Does this violate EMTALA [Emergency Medical Treatment and Labor Act]?"

The reason the question is tricky, he adds, is that enforcement by the Centers for Medicare & Medicaid Services (CMS) varies from region to region and from state to state. In one region, he says, the answer will be different depending on the EMTALA enforcement person who is being asked.

"As always, my approach is to watch what the regional office does — not what they say," says Frew, who advises providers to watch for patterns to determine what is likely to happen.

He describes a scenario in which a patient with a fracture comes to the ED, and staff there contact the on-call physician, who tells them to splint the broken bone and send the person to the physician's office the next day. When the patient arrives, it is determined that he or she is uninsured, and the on-call physician refuses treatment.

"The first question is whether this is EMTALA-[related] at all," Frew says, "and the answer is that most CMS investigators would consider it [to be] — at least until they complete the investigation."

That means a complete review of the incident, similar cases, and a broad range of other EMTALA issues, he says. "Just getting a visit makes it much more likely that the feds will find 'something' or multiple 'somethings' to cite you on. Visits are not good things."

The next question to look at is whether or not the on-call physician was asked to come in to see the patient, Frew says. "If the physician was asked to come in but refused and requested that the patient be sent to the office the next day, there is an 'on-call violation' in most instances, which means there is also a potential hospital violation.

"If the ED physician caved in and agreed to send the patient to the office after asking the on-call to come in, then we have a probable ED physician violation for an improper transfer and on-call violation."

Another issue is whether splinting constitutes "stabilization," he points out. "Some EDs cast simple fractures, while others tend to splint and send the patient to the [orthopedic surgeon] later for casting. CMS has cited both practices," Frew says.

Several points come into play here, he says, including the following:

- If the issue of further evaluation is involved, CMS almost always considers that the patient requires this evaluation in the ED setting.
- Sending a patient for prompt or immediate specialist review implies that the risks to the patient have not been resolved.
- Splinting, because it is considered an interim

measure, it often viewed as incomplete treatment by CMS and not sufficient to be considered "stabilization."

Discharging for outpatient care

CMS rules talk vaguely about it being permissible to discharge from the ED for outpatient care in appropriate circumstances, but do not give "safe harbor" guidelines, Frew says. The agency is more likely to accept this approach in the following instances, he suggests:

- Necessary testing has been done to confirm that the injury is of a limited and minor nature.
- Casting has been performed in the ED or is documented as inadvisable.
- The specialist has agreed to see or manage the patient.
- Specialty care is not needed on an expedited basis.
- Good documentation shows elements of medical screening examination, stabilization, and plan of care.

When anything does go wrong, it is virtually certain that the hospital will get cited, Frew advises. "In 90% of the cases like our scenario, the ED physician gets faulted for the violation, as well as for inadequate evaluation, improper discharge, failure to call in the on-call [physician] or sending to the office."

While there is no "one-solution-fits-all" answer to avoiding problems, he says, the following approaches have been found to generate the fewest citations:

- Testing, evaluation, and casting of minor fractures is done in the ED.
- More involved fractures require the specialist to examine the patient in the ED.
- Definitive care of complex fractures, pain management, and tendon repairs are done before discharge.
- Specialists who are asked to come in are not allowed to substitute their office as the treatment site.
- Medical staff rules that require and enforce ED follow-up visits without regard to means or ability to pay. ■

NEWS BRIEFS

Report: Better access linked to better quality

Health scorecard ranks states

Health system performance varies widely across states, with better access associated with better quality, according to a scorecard released recently by a Commonwealth Fund commission.

The state scorecard assesses health system performance on 32 measures of access and quality, avoidable hospital use and costs, equity, and healthy lives. Results show no systematic relationship between the costs of care and quality across states.

If all states performed as well as the top quartile, the panel estimates the nation annually would save billions of dollars and have 90,000 fewer deaths under age 75 from preventable conditions, and half as many uninsured people.

States in the upper Midwest and Northeast were heavily represented in the top quartile of the scorecard, and those in the lowest quartile were concentrated in the South.

The 13 top states are Hawaii, Iowa, New Hampshire, Vermont, Maine, Rhode Island, Connecticut, Massachusetts, Wisconsin, South Dakota, Minnesota, Nebraska, and North Dakota. The 13 states at the bottom are California, Tennessee, Alabama, Georgia, Florida, West Virginia, Kentucky, Louisiana, Nevada, Arkansas, Texas, Mississippi, and Oklahoma.

Uninsured rates are well above average in the lowest quartile, and more than double those in the top quartile.

To improve performance across states, the commission calls for universal health coverage, more info on practices and policies that con-

COMING IN FUTURE MONTHS

- Achieving registration 'transparency'
- Strategies for staff training
- Access regulatory update
- Denial management success stories
- More revenue cycle technology

tribute to high or varying performance, and nationwide collaboration across public and private sectors. ▼

Medicare beneficiaries to track health services

Some Medicare beneficiaries will be able to access and use a personal health record (PHR) to track their health care services under an 18-month pilot project announced recently by the Centers for Medicare & Medicaid Services (CMS).

Beneficiaries will have access to their registration information, such as name, address, and policy numbers, as well as to lists of their medications and medical conditions, which will be available at www.mymedicare.gov.

CMS also will seek to identify the minimum content and functionality of the PHR tools and assess the best methods for outreach and education to encourage adoption and ongoing use. ▼

IRS issues Q&As on tax-exempt hospitals

The Internal Revenue Service has issued a question-and-answer document clarifying its earlier memorandum allowing tax-exempt hospitals to share health information technology (IT) with physicians.

The document explains that health IT arrangements between hospitals and medical staff physicians that are not entirely consistent with the memorandum "will not necessarily result in any impermissible private benefit or inurement."

The memorandum is not meant to describe the only permissible health IT arrangements, but the facts and circumstances of any such arrangement would need to be reviewed by the IRS to determine if it is permissible, the Q&A document states.

The May 11 memorandum was issued in response to tax-exempt hospitals' concerns that they risked their tax-exempt status if they shared health IT with physicians as new Stark and anti-kickback rules permit. ■

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

Privacy advocates say GAO testimony against HHS too soft

Critics say changes to HIPAA privacy rule have not helped, question its ability to safeguard privacy

While the Government Accountability Office (GAO) criticized the Department of Health and Human Services (HHS) for not making enough progress in developing a federal privacy policy, some privacy advocates were quick to say the GAO was not strong enough in its criticism.

The GAO testimony before a House Committee on Oversight and Government Reform subcommittee summarized its January 2007 report to Congress that said HHS still needs to define and implement an overall privacy approach that identifies milestones for integrating the outcomes of its initiatives, ensures that key privacy principles are fully addressed, and addresses challenges associated with the exchange of health information.

GAO said challenges to exchanging electronic health information exist in four areas:

1. Understanding and resolving legal and policy issues. As health information expands across state lines, GAO said, organizations are challenged with understanding and resolving data-sharing issues introduced by varying state privacy laws. HHS intends to identify the variations in state laws through the privacy and security solutions contract it awarded in 2005, the testimony said.

2. Ensuring appropriate disclosure. Several organizations described issues associated with ensuring appropriate disclosure, such as determining the minimum data necessary that could be disclosed for requestors to accomplish the intended purposes for use of the health information. In June 2006, the National Committee on Vital and Health Statistics recommended that HHS monitor development of different approaches and continue an open, public process to evaluate whether a national policy would be appropriate.

3. Ensuring individuals' rights to request access and amendments to health information to ensure it is correct. GAO said that as the exchange of personal health information expands to include multiple providers and as individuals' health records include increasing amounts of information, keeping track of the origin of specific data and ensuring that incorrect information is corrected and removed could become increasingly difficult. Also, as health information is amended, HIPAA rules require covered entities make reasonable efforts to notify certain providers and other people that previously received the individuals' information.

4. Implementing adequate security measures for protecting health information. Adequate implementation of security measures is another challenge that health information exchange providers must overcome, GAO said.

Department changes its position

While HHS initially disagreed with GAO's recommendation that it define and implement an overall approach for protecting health information, after the report had been out for awhile, the National Coordinator for Health IT agreed with the need for an overall approach to protect health information and said the department was taking steps to address the recommendation.

Also, since the report was issued, HHS said it has undertaken additional activities to address privacy and security concerns. Among those steps, the National Committee on Vital and Health Statistics' Subcommittee on Privacy and Confidentiality is drafting additional recommendations for the secretary of HHS on expanding the HIPAA privacy rule coverage to entities not currently covered; the privacy and security solutions contractor is in the process of analyzing and summarizing 34 states' final assessments of organization-level business practices and summaries of observations and key issues; and

HHS awarded a contract on the State Alliance for e-Health, intended to address state-level IT issues.

Responding to GAO's original report, the Health Privacy Project's deputy director, **Paul Feldman**, resigned as co-chair of the American Health Information Community's Confidentiality, Privacy, and Security Workgroup. "We have determined we are unable to continue given that the workgroup has not made substantial progress toward the development of comprehensive privacy and security policies that must be at the core of a nationwide health information network," the group said.

HIPAA privacy has been changed

Likewise, the organization PatientPrivacyRights said while it agreed with GAO on the need for a comprehensive privacy approach, it disagreed with the recommendation that HHS should ensure that key privacy principles in HIPAA are fully addressed. Chairperson **Deborah Peel**, a psychiatrist, said those making that recommendation wrongly assume that HIPAA still gives Americans the right to privacy.

"The key defect in the [GAO] report," the group said, "stems from the authors' lack of understanding that the 2002 amendments to the HIPAA privacy rule eliminated the patients' right of consent by replacing the consent provisions in the original HIPAA privacy rule with regulatory permission granted to more than 600,000 covered entities to use and disclose personal health information for treatment, payment, and health care operations… Without the right of consent, which ensures patients' right to medical privacy, it is impossible to ensure privacy in a national HIT system."

PatientPrivacyRights called on HHS and Congress to:

- restore the individual's right to medical privacy;
- provide strong privacy standards appropriate for electronic health systems; and
- require HHS to report to Congress annually on protection of privacy rights.

"Neither the GAO or HHS can face the obvious fact that since HHS gutted the HIPAA privacy rule, relying on it as the federal standard for privacy, it cannot possibly ensure privacy," Peel said after GAO's testimony. "The GAO and HHS expect Congress and the nation to go along with the pretense that HHS and HIPAA are protecting our privacy when our records are naked for covered entities to see, use, and disclose for virtually any reason. It is almost impossible to conceive of a use of protected health information that would not fall under one of the three categories of treatment, payment, or health care operations, [and thus] covered entities are free to data mine and sell Americans' health records."

And privacy critic James Pyles, a Washington, DC, attorney, said the situation is actually much worse than described by GAO because the report "fails to acknowledge that there is wide consensus about necessary health information privacy protections in constitutional common law, the statutory and common law pertaining to the physician-patient and psychotherapist-patient privilege, and state privacy laws for mental health, HIV/AIDS, genetic, and cancer information."

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Appearing before the subcommittee, Healthcare Leadership Council Executive Director **Mary Grealy** defended the current amended version of the HIPAA privacy rule, which she said her organization helped shape. The council has 34 members, including a dozen provider organizations and a greater number of pharmaceutical manufacturers and resellers.

"We are concerned that the transition to more widespread use of electronic medical records will prompt a reactive advocacy in some quarters for additional burdensome privacy regulations," she said. "It's important to note that the HIPAA privacy rule, which is already quite restrictive, was spurred by the growth in electronic transactions and contains ample provisions governing the confidentiality of information, electronic or otherwise. It's even more important to recognize that more restrictive rules, such as requiring providers and payers to obtain prior consent to treatment, payment, and health care operations would have a counterproductive and harmful impact on patient care. While HIPAA establishes a federal privacy standard, it permits state variations that are found in thousands of statutes, regulations, common law principles, and advisories."

And American Hospital Association Regulatory Counsel **Lawrence Hughes** said hospitals favor a national standard on privacy but see the need for a balance between protecting patients' privacy and treatment. "If you returned the privacy rule to its original version," he warned, "there would be significant obstacles to providing good quality care to patients." Hughes also said his association has no complaint about HHS's pace and process.

At the same hearing, the American Health Infor-

mation Management Association (AHIMA) said Congress should act to expand protections for personal health records, resolve inconsistencies in HIPAA, and pass comprehensive non-discrimination legislation penalizing the intentional misuse of an individual's health information.

Pickard said that while his group wants to see consumer-based personal health records, in addition to standard provider-based electronic health records, this can't happen until the industry resolves important issues including expansion of privacy protections for personal health records, differences between HIPAA "business-associated" and non-covered third-party contractors, and protecting student health information by resolving conflicts that include HIPAA.

(Editor's note: You can download the GAO testimony at www.gao.gov/new.items/d07988t.pdf.) ■

HHS launches web site on HIPAA privacy compliance

Provides information on corrective actions taken

To coincide with the fourth anniversary of enforcement of the HIPAA Privacy Rule, the Department of Health and Human Services (HHS) launched a new web site to provide information about how it enforces health information privacy rights and standards compliance.

The web site (www.hhs.gov/ocr/privacy/enforcement) describes HHS activities in enforcing the Privacy Rule, the results of those enforcement activities, and statistics showing which types of complaints are received most frequently and the types of entities most often required to take corrective action as a result of consumer complaints.

As of May 31, HHS and its Office of Civil Rights (OCR) had investigated and resolved more than 4,732 cases by requiring changes in privacy practices and other corrective actions by the covered entities.

In another 2,282 cases, HHS found no violation had occurred. In the rest of the 14,787 completed cases, HHS determined that the complaint did not present an eligible case for enforcement of the Privacy Rule. These include cases in which:

- OCR lacks jurisdiction under HIPAA — such as a complaint alleging a violation prior to the compliance date or alleging a violation by an entity not covered by the Privacy Rule;
- the complaint is untimely, or withdrawn or not pursued by the filer; or
- the activity does not violate the rule, such as when the covered entity has disclosed protected health information in circumstances in which the rule permits such a disclosure.

The compliance issues investigated most frequently were, in order of frequency: impermissible uses and disclosures of protected health information; lack of safeguards of protected health information; lack of patient access to their protected health information; uses or disclosures of more than the minimum necessary protected health information; and lack of or invalid authorizations for uses and disclosures of protected health information.

The most common types of covered entities that have been required to take corrective action are, in order of frequency: private practices, general hospitals, outpatient facilities, health plans (group health plans and health insurance issuers), and pharmacies.

OCR refers to the Department of Justice for criminal investigation-appropriate cases involving the knowing disclosure or obtaining of protected health information in violation of the rule. As of the date of its summary, OCR had made more than 400 such referrals to DOJ.

OCR refers cases that describe a potential violation of the HIPAA Security Rule to the Centers for Medicare & Medicaid Services (CMS). As of the May 31 date of the summary, OCR had made more than 171 such referrals to CMS. In the referred cases that describe potential violations of both the HIPAA Privacy and Security Rules, OCR and CMS coordinate the investigations.

HHS says it also obtains privacy compliance through outreach and education efforts. OCR has reached hundreds of thousands of covered entities and consumers through educational conferences, a toll-free call line, and an interactive web site. ■

Audit raises concerns of data security requirements

Audit first of its kind

A U.S. Department of Health and Human Services (HHS) audit at Piedmont Hospital in Atlanta is raising concerns in the information technology industry that there may be more HHS enforcement actions relating to HIPAA data security requirements.

Computerworld says the audit was the first of its kind under HIPAA and involved 42 items HHS wanted information on, according to documents it obtained. Among those: the hospital's policies and procedures on 24 security-related issues, including physical and logical access to systems and data, Internet use, violations of security rules by employees, and logging and recording of system activities. Also requested were IT and data security charts and lists of the hospital's systems, software, and employees including new hires and terminated workers.

Security Director **Randy Yates** at Houston's Memorial Hermann Health System told the magazine that everyone in the industry is aware of the audit and said it contributed to approval of his $1.3 million budget item for data encryption in the next fiscal year. Yates said Memorial Hermann did a gap analysis after hearing of the audit and took steps to improve the areas in which it was at the greatest risk for noncompliance. He expressed confidence in the measures taken to comply, but said a lack of detailed public information about what HHS was looking for (neither the agency nor the hospital has confirmed the audit) was "a little bit disconcerting."

Healthcare Information and Management Systems Society Director of Privacy and Security **Lisa Gallagher** said it was puzzling that it appeared the audit was conducted by the HHS inspector general. She said most people in the industry have assumed that any security-related enforcement actions would come through the Centers for Medicare & Medicaid Services (CMS).

"Nobody really knows why the inspector general did it or what's going to be their criteria for selecting the next one," she said. She also voiced concern about the checklist approach the investigators appeared to take.

One analyst said he thought HHS decided on the audit partly because it has been under political and media pressure to enforce the HIPAA rules. He expects to see more audits in the future but doesn't think they will be too frequent, partly because the agency doesn't have enough staff to devote to them. And, despite industry buzz, he doubts the audit will lead many other organizations to step up efforts to comply with security requirements.

"Until at least several audits have been completed, and the industry sees action to enforce the HIPAA security rules, I think serious attention to compliance will not be a major focus," he said.

But **Peter MacKoul**, president of HIPAA Solutions, based in Portland, said it's not only HHS enforcement that those handling medical data need to be concerned about. Increasingly, he said, law enforcement authorities and courts are using and interpreting HIPAA in ways that could have broad implications.

Last year the North Carolina Court of Appeals overturned a trial court decision to dismiss a HIPAA-related complaint brought by an individual against a psychiatrist's office. MacKoul said the verdict basically allowed the plaintiff to use HIPAA as a "standard of care" to bring an individual action against an organization. He also said while HIPAA initially applied to electronic medical records, courts have extended it to cover paper records. ■

Companies auctioning customer records

Loophole allows auctioning off of customer records

U.S. Sen. **Charles Schumer** (D-NY) says a loophole in medical privacy law is allowing pharmacies to "auction off" customer records, including prescriptions, information about medical conditions, Social Security numbers, and insurance records "to the highest bidder."

Federal law requires doctors let patients know when their medical history is being shared, he said, but the law allows pharmacies to sell patient information to other pharmacies. Schumer said Health and Human Services Secretary **Michael Levitt** should seek a change in the law requiring pharmacies notify patients before selling or transferring their records and allowing patients to opt out.

Meanwhile, a federal judge struck down a New Hampshire law that would have blocked drug company marketing access to physician prescription information. A Washington Legal Foundation (WLF) analysis said the law would have criminalized collecting and disclosing information about physician prescribing practices.

So far, New Hampshire is the only state to try to prohibit disseminating information on doctors' prescribing patterns. "A handful of doctors seem to think that laws of this sort protect their privacy," said WLF Chief Counsel **Richard Samp**. "But if more such laws are adopted, the loser will be the American health care system. The information that New Hampshire is trying to ban plays a vital health care role; it is used to monitor the safety of medications, implement drug recalls, and rapidly communicate information to doctors about innovative new treatments." ■