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Workplace engagement at Texas health system earns one of 12 Gallup awards

Mentoring program, employee dinners are among access initiatives

At Hendrick Health System in Abilene, TX — one of 12 organizations worldwide to receive the 2007 "Gallup Great Workplace Award" — the focus on workforce engagement is stronger than ever, says **Susan Wade,** CHAM, director of admissions, who oversees more than 50 employees in several access areas.

"Gallup has proven through years of research that if employees are engaged in what they do, they are more productive, safer at work, and turnover is less," she adds. "When we received our [winning] scores, we were proud, but there is always improvement to be made."

That kind of engagement has been enhanced in the admissions department by, among other things, a morale committee that plans employee activities and oversees the awarding of a quality award.

Wade, two admissions supervisors, and the department's training coordinator rotate being on call every weekend in case staff need assistance, she says. "If it's my weekend to be on call, I go in and check on the staff. I get to see employees I don't normally see during the week."

Gallup, the international survey and research organization based in Princeton, NJ, uses a 12-question survey and a best practices portfolio to determine how well organizations measure up against its criteria for engaged workforces. **(See related story, p. 123.)**

Based on Hendrick's survey results, Wade says, each department in the hospital selected a "strength" and an "opportunity" with which to build on the employee engagement the organization already had achieved.

Access employees met as a group, she notes, to choose the survey questions — actually 12 statements that are rated on a scale of one to five — that are most important to them. "We let them vote on the questions they want to work on, and then brainstorm about what we can do."

The focus is on the first six questions, Wade adds, because if those are in line "the others take care of themselves."

For example, the "strength" chosen by her staff — based on departmental results — was No. 5: "My supervisor or someone at work seems

to care about me as a person."

Three "action items," explained below by Wade, were selected to further build on that strength:

• Quarterly employee dinners.

Employees are invited to meet and have a meal together to get to know each other in a relaxed atmosphere. The overall attendance level has been about 50%.

• A 10-minute open discussion period at each departmental meeting.

This time has been spent, for example, talking about advance directives, with someone brought in to lead the discussion. The next meeting's session was to feature a Gallup tool designed to promote engagement by asking employees: What questions do you have? What suggestions do you have? What is the best recognition you've ever received? What experiences are you challenging yourself with this year?

• Adding an employee spotlight to the department's newsletter.

The monthly newsletter, "Admit Alert," is part of an on-line access department Share Page that also includes information about insurance changes and new policies. The new feature will highlight two access employees, sharing information about their families, where they grew up, and their youthful aspirations.

Survey question No. 6 — "There is someone at work who encourages my development" — was chosen as the "opportunity" for the department to explore, Wade says. "This was a place where we had a lower score than we would have liked."

Employees decided upon several action items to support that idea:

• Mentoring of new employees.

Specific people in each area of the access department are asked to be mentors, not only to answer work-related questions, but to help with issues related to the hospital. It was also suggested that these employees might, for example, include the new hires in their lunch plans.

• Cross-training employees who are interested.

This initiative builds on an effort that was already in place.

• Allow employees, on a voluntary basis, to observe in an area of the department in which they do not normally work.

This practice is also followed with new employees, who go to each area and observe before beginning work in any one area. The department recently added an employee specifically to handle forms training, and that training is now done when an employee is observing in the area where the form is used.

• Quarterly meetings.

These meetings involve two entities for which a cooperative relationship is essential. The meeting might be between two different parts of the admissions department, or between scheduling and radiology — any areas that work closely together and may have questions for each other. Originally arranged under the direction of area supervisors, Wade explains, the practice has evolved into a more informal process whereby groups schedule a meeting if an issue needs to be addressed.

"What we find," she adds, "is that we begin

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Editorial Questions

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12 employee expectations part of 'engagement' survey

High scores linked to strong performance

Researchers at Gallup have identified 12 employee expectations that, when satisfied, form the foundation of strong feelings of engagement in the workplace. Out of that research, the company created a survey in which employees rate their response to 12 statements on a scale of one to five.

High scores on the survey, shown below, have been linked to strong worker performance and good business outcomes, the company says.

1. I know what is expected of me at work.
2. I have the materials and equipment I need to do my work right.
3. At work, I have the opportunity to do what I do best every day.
4. In the last seven days, I have received recognition or praise for doing good work.
5. My supervisor, or someone at work, seems to care about me as a person.
6. There is someone at work who encourages my development.
7. At work, my opinions seem to count.
8. The mission or purpose of my company makes me feel my job is important.
9. My associates or fellow employees are committed to doing quality work.
10. I have a best friend at work.
11. In the last six months, someone at work has talked to me about my progress.
12. This last year, I have had opportunities at work to learn and grow.

Award criteria

To be eligible for the Gallup Great Workplace Awards, applicants must meet the following criteria.

1. Have a sample size of at least 1,000 employees.
2. Have a survey response rate of 80% or higher by employees.
3. Have a GrandMean score of 4.15 out of five or higher in at least half the organization's work groups.
4. Submit business impact results that link workplace engagement to business outcomes.
5. Submit a best practice portfolio that includes:
   - A strategic plan and proof of implementation in a summary of steps taken to increase workplace engagement.
   - Examples of best practice organization-wide initiatives and best practice workgroup level plans.
   - Examples of a total program or process that have been used or created to increase engagement in the workgroup. ■

things and just keep building and adding to them. If you do the same thing over and over, it can get stale."

As Hendrick personnel have initiated efforts toward enhancing workplace engagement, Wade says, "we've also found that it's important to tie it all back together, to remind people of what we're doing: This is the plan, this is the progress we've made, and if it's not working, eliminate it."

Getting employees involved in improving their own morale and in creating ways to increase engagement is key, she emphasizes.

One of the ways the admissions department has recently tweaked its workplace initiatives, Wade notes, is to have the various work groups report directly to supervisors rather than be assigned on a department-wide basis.

"We wanted some personal accountability," she says. "What happens with a big group is that a lot of times it's a select group of people [doing the work]."

In one of the areas that reports directly to her, Wade adds, "the employees decided they want to revise the training process and make it a little more formal."

Another idea was to introduce new hires to the department in a more formal way, so those employees will interview their new colleagues and submit the information to the "Admit Alert" newsletter.

Keeping in mind that employee engagement is driven to a great extent by the person's relationship with his or her supervisor, Wade says, she meets quarterly with staff who report to her directly.

During these quarterly sessions, Wade says, she helps staff "figure out their personal goals and their expectations of me as a supervisor, instead of me doing all the talking." To assist her in that effort, she uses a tool called the "Four Keys Coaching Guide."

Some of the questions from the guide are:

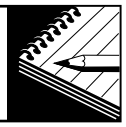
- What are your strengths?
- What do you do best?
- What do you enjoy most about your current role?
- What do you want to accomplish in the next month… the next six months?
- What do you expect of me this year?

"I especially like that last question," Wade says. "I've encouraged my supervisors to look at that tool, too."

Wade says she tries to meet with every employee in the department once a year. "My door is open always," she notes, but actually scheduling an appointment with each individual adds focus to that message.

(Editor's note: Susan Wade can be reached at swade@ehendrick.org.) ■

GUEST COLUMN



'Present on admission' rule effective Jan. 2008

Access has role to play

By **Jeffrey Smith**
Manager, Provider Administration
Accenture
New York City

More than likely, patient access managers have recently heard the term "diagnoses present on admission" discussed by their health information management (HIM) and patient accounting colleagues.

These discussions refer to the Jan. 1, 2008, Centers for Medicare & Medicaid Services (CMS) requirement for completing a present on admission (POA) indicator for primary and secondary diagnoses on inpatient acute care claims. This indicator (Y-yes, N-no, U-unknown, W-clinically undetermined) will denote whether at the time the admission order was placed, the patient had a particular diagnosis.

Certain conditions and external causes of injury are exempt from POA reporting. A listing of these codes is found in Appendix 1 of the ICD-9 CM official guidelines for coding and reporting. The POA indicator should be captured by HIM staff after their review of clinical documentation associated with the patient's admission.

Although patient access staff do not have a direct role in obtaining this information, it is important for them to be cognizant of this legislation. The impetus for CMS to institute this legislation is to determine whether specific diagnoses attributable to preventable infections and injuries (indicative of quality of care) occurred during the course of the hospital stay.

In fiscal year 2009, CMS will reduce DRG (diagnosis-related group) reimbursement in instances where these diagnoses were not present on admission. Given the operational and financial implications of the POA requirement, it is important for patient access managers to be aware of this issue and to support diagnosis delineation whenever possible.

Diagnosis delineation integral

The present on admission requirement arises from Section 5001 (c) of the Deficit Reduction Act of 2005. This legislation requires CMS to identify conditions or diagnoses that meet these criteria:

- high cost, high volume (or both);
- result in the assignment of a DRG with a higher payment when present as a secondary diagnosis;
- could have been reasonably prevented through the use of evidence-based guidelines.

Conditions meeting the above criteria include serious preventable events (air embolism, object left in during surgery, blood incompatibility), catheter infections, mediastinitis following coronary bypass surgery, and hospital-acquired injuries. As of Oct. 1, 2008, CMS will not assign claims with these conditions to a higher-paying DRG unless the condition or diagnosis was present on admission.

The term "present on admission" is defined as a condition the patient possesses at the time the decision for admission is made. Conditions arising during an outpatient encounter (emergency department, observation, outpatient surgery) will be considered as meeting the POA criteria. Documentation from any health care provider treating the patient can be utilized in determining the POA indicator.

Examples of source documentation include, but are not limited to: history and physical, physician orders, discharge summary, mid-level provider notes, nursing records (i.e. ante-partum notes), anesthesia records, consultation notes, and pathology reports. If any ambiguities or

inconsistencies exist in the documentation, it is the responsibility of the coding staff to query the treating physician, asking for clarification.

Patient access staff can support the determination of POA by asking follow-up questions when appropriate to clarify underlying conditions of registration or scheduling.

That would include, for example, noting any underlying falls or injuries that occurred just prior to the time of admission. This is especially important in instances of multiple traumas, where underlying injuries may not be noted for several days after admission.

It is also important for registration staff to correctly note reasons for patient admission when specified, as these conditions can obviously be noted as being present on admission. Appropriately capturing admitting diagnosis information will assist HIM in examining the record further to determine whether a diagnosis was pre-existing or not.

In instances in which concurrent coding or updating of diagnoses is taking place (such as involvement of case management, utilization review, or clinical documentation specialists), paying attention to whether an underlying complaint was noted at the time of registration could assist these individuals in approaching a physician about whether a diagnosis was present at the time of admission.

Correctly determining whether a diagnosis was present on admission will be a challenge for both physicians and coding staff. Patient access leadership can facilitate this process by making sure registration staff are diligent in noting injuries and admitting complaints.

Patient access managers and directors can remind physicians the POA indicator is a CMS requirement and proper capture of these data will ensure hospital quality indicators are reported correctly.

(Editor's note: Jeffrey Smith specializes in revenue cycle transformation and system implementation/integration in Accenture's health provider practice. He can be reached at j.a.smith@accenture.com.) ■

Initiative sparked by close call with DNR wristband

Effort has implications for access

A "near-miss" in which a nurse at a Pennsylvania hospital incorrectly placed a "do not resuscitate" (DNR) wristband on a patient has prompted an Ohio initiative aimed at implementing statewide standardization of colored wristbands.

The effort and the safety concerns behind it have implications for access personnel, notes **Rosalie Weakland,** director of quality improvement for the Ohio Hospital Association (OHA), particularly when it comes to the patient identification wristband, which typically is placed on the patient by a registrar.

Based on the Pennsylvania incident — which occurred because the nurse worked at multiple hospitals that used different-colored bands to designate a DNR order — an Ohio task force looked at how the process was handled by that state's providers, Weakland says. Fortunately, she notes, another nurse at the Pennsylvania facility caught the mistake just in time to resuscitate the patient.

In surveying Ohio providers, she adds, "we found 19 different colors [for wristbands], with 28 different meanings. Sometimes the same color was used for two things. For example, emergency department patients had yellow wristbands, and then when they became inpatients, a yellow wristband was for a person who was at high risk for a fall."

The task force, convened by the Ohio Patient Safety Institute (OPSI), set an ultimate goal of eliminating all wristbands except those used for patient identification, in favor of electronic tracking systems, Weakland says. But because many providers are not ready for that step, she adds, an interim goal of standardizing and reducing the colors used for wristbands to four was established.

The OPSI now recommends that all Ohio providers adopt the following standard wristbands: 1) white/clear for patient identification; 2) red for a known allergy; 3) yellow for a high fall risk; and 4) green for blood products (if a patient is supposed to get platelets or a unit of blood).

A national standard

"My ultimate mission is a national standard," Weakland notes. "Health care professionals go across the nation and, depending on locations, hospitals transfer patients across state borders." Different colors between states can lead to problems, "so we're trying to get our bordering states to have consistent colors."

The first thing access professionals can do regarding the issue, she suggests, "is try to pro-

mote a standardized wristband for patient identification. I personally recommend that all [providers] go with white in all locations — ED and ambulatory surgery, for example — not just for inpatients."

Depending on the setting, access personnel could potentially also look at DNR wristbands, Weakland says, "because a lot of registrars ask [about DNR instructions] as an initial question. If that is the case, be aware of the [type of] wristband that is appropriate for their state."

Some registrars also are in the position of asking about patient allergies, she says, in which case they should be aware of the appropriate wristband for that condition. "Red tends to be the wristband color for [allergies] across the country, DNR is mostly purple, and yellow is consistent for fall risk."

Some states, however, use colors differently, Weakland says, including many that indicate the need for blood products with a red wristband. Ohio is the only state that is required by law to indicate a DNR order with white paper inside of a clear wristband, she points out.

State activists hope to get that law changed, Weakland adds, and because it is under review, the task force is not making a recommendation regarding DNR wristbands at this time.

The contention of the Ohio task force — which comprise representatives from hospitals, home health agencies, ambulatory facilities, and hospice organizations — is that the number of different wristbands used should be limited to four in order to avoid confusion, she explains.

Some hospitals use additional wristbands to indicate things such as which side of the body is scheduled to receive surgery or that a particular limb should not be used to draw blood, Weakland says, but her belief is that having too many increases the chance of error.

"The fewer the better," she says. "These [four] are the high-volume ones. If we [replace the bands with] technology, the fewer we have to delete, the better."

While leading-edge hospitals at present are moving toward bar coding as the alternative to banding, Weakland notes, "technology changes so fast that there may be something additional that will be used."

Another task force recommendation that relates to registration personnel, she adds, is that patients remove community wristbands such as the "Live Strong" band inspired by Lance Armstrong during their hospital stay.

Access staff should "start sending that message during registration," Weakland suggests. "In an emergency, even though those bands are made from different materials, you could have confusion. Encourage patients to remove [community wristbands] and send them home, or save them until after discharge."

(Editor's note: More information is available at www.ohiopatientsafety.org. Rosalie Weakland can be reached at rosaliew@ohanet.org.) ■

Career Paths

PFS director develops 'personal renovation plan'

'The key is to stop and look at yourself'

After 22 years as director of patient financial services at Watauga Medical Center in Boone, NC, **John D. Cook Jr.** reached the point where he had "no drive, no energy, and no motivation."

"It was very clear to me that it was time to do something else," says Cook. "I gave a 60-day notice and my last day was June 28, 2002."

That step led to the development of what he calls his "personal renovation plan" and ultimately to a job he loves and plans to keep until retirement.

First, however, Cook took a couple of months off, and then spent about a year serving as interim CEO for a large physician group. Later he freelanced and did consulting work and motivational speaking before joining Data Image of Charlotte Inc. in May 2006 as director of sales and marketing.

"There were ups and downs and total adjustments," he recalls. "The whole key is to stop and look at yourself and then look at the steps you can take to become a better leader."

One of the biggest insights he gained during this period, Cook says, "is that if your drive is lacking, if your motivation is lacking, you can't expect your staff to have those things. It all starts at the top."

Now, Cook says, he is in a professional role in which he is able to add value to others' lives through providing products and services and by

Charting the Course to Renewal

Personal Renovation Process

What are your personal Principles, Practices, and Priorities?

_____
_____
_____
_____
_____

Which of these do you feel need some "renovation work"?

_____

What do you believe your Personal Mission to be?

_____

Chart Your Course: What will be your Personal Renovation Plan?

_____
_____
_____
_____
_____

Begin It Now

I proudly say I am

_____
_____

I am clear about my mission. I commit my passion to this cause. This cause will create new energy for myself and others.

building one-on-one relationships. He continues to do motivational speaking as a hobby.

"Our company slogan is, 'We want to help you put the pieces of the puzzle together,'" he adds. "I carry that through everything in my life.

"To be honest, as I look back, I got to this role by charting a personal course to renewal," says Cook, who now shares his experiences and observations on personal and career development with groups such as the North Carolina Association of Healthcare Access Management. He spoke at that organization's annual conference in Carolina Beach in September 2007.

What Cook finds is that the intensity and pressure of today's health care environment has taken many of the access directors and managers he meets to the point of personal and professional exhaustion.

'Nip it' before you burn out

"They may not have reached the burnout point, but they're getting there," Cook says. "They need to nip it before they get to burnout, which can lead to depression."

His answer, based on his own experience, is to "do a personal renovation process. Stop and look at your principles, priorities, and practices. You might find that you've got principles and priorities, but you're not practicing them." **(See worksheet, this page.)**

First, Cook suggests, honestly answer these questions:

1. Do you believe that your fire needs to be reignited?
2. Are you willing to take the steps to do that?
3. Will you commit to at least taking a look in the mirror?

Continuing the process, he says, look at these critical areas:

1. What motivates you to get up and do your job?
2. What is your passion? (If you don't have one, you need one.)
3. Are you actively engaged in your career or are you detached from it?
4. In all honesty, can you say that you embrace where you are?

One of the things Cook did during his years as patient financial director that he recommends to those in similar positions was to arrange an annual retreat for his staff.

"We did it over two days — because half the staff had to be at the hospital — but we got away, we went to a nice place, and we did exercises that helped them grow, but nothing related to work," he says.

The retreat "was all about them," Cook adds, "and they got to know each other better and started understanding the things they can do for themselves to be better people."

His own personal renovation involved, among other things, quitting smoking and losing weight. A practice that has become part of his life, he notes, is making sure at a certain point to leave his home office — where it is easy to get caught up in working late hours on the computer — and go upstairs to spend time with his wife.

With all the volumes that have been written

about leadership, Cook adds, he believes his own list of principles, while simple, is also profound:

- Have a servant's heart.
- Listen and be accessible.
- Help those you lead to add value to their lives and be successful.
- Create an atmosphere charged with meaning and purpose.

(Editor's note: John Cook can be reached at jcook@dataimageofclt.com.) ■

CMS keeps emphasizing patients' right to choose

Discharge guidance refers to BBA

Federal regulators continue to make it clear that they are serious about patients' right to freedom of choice of providers, says **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

Draft supplemental compliance guidance published recently by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, Hogue notes, refers to requirements of the Balanced Budget Act (BBA) of 1997. The excerpt below, she adds, specifically relates to patients' freedom of choice:

"When referring to home health agencies, hospitals must comply with section 1861(ee)(2)(D) and (H) of the Act, requiring that Medicare participating hospitals, as part of the discharge planning process, (i) share with each beneficiary a list of Medicare-certified home health agencies that serve the beneficiary's geographic area and that request to be listed and (ii) identify any home health agency in which the hospital has a disclosable financial interest or that has a financial interest in the hospital."

Based upon that excerpt, Hogue says, the OIG has shown a clear willingness to treat violations of the requirements of the BBA as a form of fraud and/or abuse of federal health care programs.

The OIG also indicated that it has authority to exclude individuals or entities from participation in the federal programs if they provide unnecessary items or services, she adds, such as those in excess of the needs of the patient, or substandard items, including those of a quality that fail to meet professionally recognized standards of health care.

The OIG further states that knowledge and/or intent are not required for exclusion under this provision, Hogue continues. The exclusion can be based upon unnecessary or substandard items or services provided to patients, she says, even if the care provided is not paid for by the Medicare or Medicaid programs.

Violations of hospital conditions of participation, including those that govern discharge planning, or any other applicable standards of care may result in either over- or under-utilization of services and sanctions by the OIG. "It is logical to conclude that applicable standards of care also include the requirements of the BBA."

Consequently, she adds, hospitals that violate applicable standards of care related to patients' right to freedom of choice of providers and discharge planning may be subject to sanctions by the OIG.

"It is also important for discharge planners and case managers who work for hospitals to know that there is a broad array of tools available to providers and regulators to enforce patients' rights," Hogue says, including the following:

- Helping patients pursue violations of their common-law rights to freedom of choice of providers regardless of payer source or type of care rendered primarily through the use of signed statements that describe violations.
- Helping patients pursue violations of two federal statutes that guarantee Medicare and Medicaid patients the right to freedom of choice of providers primarily through the use of signed statements that describe violations.
- Reports to the Centers for Medicare & Medicaid Services (CMS) regional and central offices of violations of patients' rights to freedom of choice of providers by providers who participate in the Medicare/Medicaid programs.
- Reports about violations of patients' rights to state surveyors who treat such information as complaints and conduct surveys of hospitals and other providers that participate in the Medicare and Medicaid programs.
- Reports to the OIG of violations of patients' rights to freedom of choice of providers and/or violations of applicable standards of care that may result in sanctions against providers.

"There are more and more avenues for both patients and providers to pursue violations of patients' right to freedom of choice of providers," Hogue says. "Discharge planners and case managers should be proactive when they encounter such violations."

(Editor's note: Elizabeth Hogue may be reached at ehogue5@comcast.net.) ■

Poster alerts patients to discharge responsibilities

Markers allow family members to write questions

Patients at Seton Medical Center are made aware of their proposed discharge date early in the stay through a laminated poster with a Wizard of Oz theme titled "The Road Home."

The 11x17-inch poster, written in English and Spanish, prompts patients to ask questions ahead of time instead of waiting until the day of discharge.

"We provide dry-erase markers that allow family members and patients to jot down questions and communicate back and forth with the nurses and case managers, and to get their questions answered in a timely manner so they'll be prepared for discharge," says **Patricia Ramming**, RN, network director of patient logistics at Seton Healthcare Network in Austin, TX.

The poster includes questions patients may want to ask about discharge, such as details about diet, post-discharge activities, and medications they will have to take. It includes other questions such as, "Are you going to have problems getting your prescription filled?" and "Do you have transportation home?"

Using the poster to get patients ready for discharge is one of a series of throughput initiatives that are part of a partnership among case management, the clinical staff, admitting, and the housekeeping department.

For instance, the case management team compares the hospital's length of stay, weighted for acuity, to other hospitals and targets Seton for the top 10%.

In 2004, faced with an increasing number of patients on hold overnight in the emergency department, Seton Medical Center created a throughput department that operates 24 hours, seven days a week. Department staff include house supervisors, express admissions nurses, and nonclinical bed board staff. The hold time in the emergency department dropped dramatically after the department was created.

"We are continually looking at ways to be more efficient on the discharge end. We typically run at 85% capacity and are looking at ways to get more beds utilized without increasing our capacity," Ramming says.

Among the initiatives are a daily bed briefing to discuss bed and staffing issues for the day; a discharge team that brainstorms about patients with complex discharge needs; and a network-wide bed board that tracks capacity throughout the entire hospital system.

Representatives from all areas of the hospital, including charge nurses from every floor, managers and directors of every department, case management, and human resources, attend the morning bed briefing.

The multidisciplinary team also includes representatives from plant operations in case there are mechanical issues; central supply, which provides all patient care equipment; and environmental services so they know what to expect and can staff as needed for the projected volume for the day. The house supervisor leads the meeting.

"We share the plan for the day, looking at all discharges and arrivals and identifying areas where there might be bottlenecks. We work as a team to expedite the admissions and discharges we know about in the morning," Ramming says.

The team comes up with a plan to ensure that admissions and discharges flow smoothly throughout the day. For instance, if the ICU is at capacity, and there are patients scheduled for surgery who will need to be in the ICU, the ICU team facilitates moving patients out if they can be transferred safely to another unit.

"The ancillary departments are part of the multidisciplinary team and we problem-solve together on ways to expedite the tests and procedures patients need before discharge. For instance, we have teamed with the laboratory to develop a bright-pink sticker that shows we need these labs run first," she says.

Dealing with complex discharge needs

A discharge team meets weekly to discuss discharge options of patients with complex discharge needs. The team includes case management, nursing, admitting, and sometimes social work, depending on the needs of the patient.

The team discusses any obstacles to discharge, including financial constraints if the patient is stable enough to move to another level of care.

"We determine if we need to get financial clearance with a post-discharge provider. If the patient has Medicaid pending, we have contracts

with post-acute providers so that Seton provides the financial support to the patient; then once Medicaid is approved, the facility reimburses us," Ramming says.

The team conducts a cost-benefit analysis to determine if it's cheaper to pay for a lower level of care instead of keeping the patient in acute care.

"This arrangement helps decrease length of stay and frees up the bed for patients whose care is covered by a payer," she says.

Each hospital site has a patient flow committee, a multidisciplinary team that meets once a month to examine any type of discharge problems that come up regularly. The system is expanding the initiative to the network level with a network committee that will share successful initiatives with peers in other Seton hospitals.

Bedside discharge

The hospital has eliminated one step in the discharge process, sending financial counselors to patient rooms to go over billing issues and collect copayments rather than having them stop by the admissions office on their way out of the hospital.

When the patient tracking system indicates that a discharge is pending, the financial counselor clears it with the nursing staff and goes to the patient's room. The initiative is called courtesy discharge rounds and was started at one site and has been rolled out across Seton's campuses.

"It's more private to have a discussion in the room and the patients are more relaxed. This has eliminated having several patients waiting at the admissions office at one time," she says.

The hospital's electronic bed board gives the staff real-time information on what beds are ready for patients, which ones are being cleaned, which are blocked, and pending discharges and admissions. It allows the admissions staff to determine when beds will be needed on which unit and sets priorities for the housekeeping staff.

The board includes information about scheduled admissions for the next five days, giving staff the opportunity to make sure paperwork is in order before the patient arrives.

"The admissions case manager can see when a bed request comes in and can proactively make sure the documentation is in place so that the patient meets InterQual criteria," she says.

Physician offices can make one call to find out capacity in any Seton hospital.

"We have systems in place to give an upcoming admission visibility. Admissions can complete the insurance verification; the case manager can review the doctor's orders ahead of time and make sure the patient meets InterQual criteria," she says.

The system helps with forecasting and scheduling of patients. For instance, Seton does not have an outpatient infusion center and anyone who is receiving a blood or chemotherapy infusion must be in an inpatient bed. If someone is coming in for a blood transfusion or chemotherapy and one campus is at capacity, the bed board staff can divert the patient to a facility that can serve them immediately rather than having them wait.

When a physician calls the central phone number to admit a patient to a particular hospital, staff can see instantly if the hospital is full.

"If Seton Medical Center is full, they can tell the doctor that there is a potential discharge in four hours or they can admit the patient directly to Seton Northwest," she says.

The bed board gives the staff the ability to visualize the emergency department's volume at all hospitals within the system.

"If we're getting a transfer request for a tertiary care center, we can focus that request to the emergency department that can handle the patient," she says.

The Seton network has a zero-diversion agreement with the local emergency medical systems. The EMS system can communicate through the Seton system and find out which hospitals have capacity in the emergency department and bed availability.

"Our network includes a Level II trauma center, a children's center, a cardiac and heart transplant center, and other tertiary care centers. Whenever possible, we can triage patients to the most available facility for stabilization and transfer them to other facilities where they can get the care they need," she says.

Other initiatives include:

- Creating the position of an express admissions nurse who floats through the hospital and helps whenever needed, getting the paperwork started, conducting a history and physical, drawing blood, or taking care of other admission needs for the patient.
- Expanding the patient tracking system so that the admissions staff can see projected discharges in a timely manner and work up front to collaborate with case management and nursing staff to identify where and when beds will be available.
- Piloting a new case management structure on some floors. "Instead of case managers being

located geographically in the unit, we are focusing more on the patient illness and scope of services," she says.

For instance, the same case manager follows a pulmonary patient from the ICU to the floor, instead of handing it off to another case manager when the patient is transferred to a different unit.

"We have reestablished the relationship that the case management team has with the utilization review team. The utilization review team works in partnership with the case managers proactively for the patient instead of getting involved on the back end," she says.

(For more information, contact Patricia Ramming, RN, network director of patient logistics, Seton Healthcare Network, e-mail: pramming@Seton.org.) ■

RWJF project tracks data to check equality of care

Most facilities don't have uniform system

The question of whether America's hospitals provide the same level of care regardless of a patient's race, ethnicity or language is being addressed in an initiative by the Robert Wood Johnson Foundation.

Ten hospitals are taking part in a collaborative focused on tracking data to identify whether there are racial and ethnic disparities in the cardiac treatment they provide while at the same time working to improve the quality of care, the foundation reports (www.rwjf.org).

While U.S. hospital leaders say they provide the same level of care regardless of race and ethnicity, few know for sure, the RWJF report contends, because most hospitals do not have a uniform system for tracking the race, ethnicity, and language preferences of their patients.

Those that do collect data often "eyeball' patients to make those determinations, rather than asking patients directly, the report says, and hardly any hospitals use data to determine how their care of minority patients compares to other known quality standards.

The Expecting Success program, as it is called, is helping the 10 hospitals produce consistent data on more than 20 cardiac care quality indicators, all analyzed by patient race, ethnicity, and language.

The program's staff suggest several key steps to help begin the data collection process:

- **Gather opinions from top to bottom.**

It's important to discuss the purpose and process for data collection with everyone from the CEO to front-line staff.

- **Affirm the legality of the process.**

Some hospitals think it's illegal to collect these data, but published research from a variety of sources affirms its legality for improving quality.

- **Identify the time and place for data collection.**

All sites involved in the program determined a time, place, and person responsible for gathering the data. It usually takes place at registration.

- **Think through the technology issues.**

Information technology staff must ensure the data transfers to all relevant patient databases — including programs that track the specific care received.

- **Use consistent categories.**

The current race and ethnicity categories used by the Office of Management and Budget are the recommended standard.

- **Have patients provide the information.**

All sites rely on patients or their caregivers to provide the information, rather than registration staff "eyeballing" patients.

- **Provide detailed staff training.**

Sites provided sample scripts, role-playing, and trouble-shooting scenarios to make registration staff comfortable.

The Health Research & Educational Trust, a division of the American Hospital Association, has developed a toolkit to guide hospitals through the process of collecting data on race, ethnicity, and primary language.

The kit, which includes nuts and bolts information, such as sample scripts and other resources for training staff, can be accessed at www.hretdisparities.org. ■

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Revenue cycle leadership a trend with staying power

Viable candidates must have experience on both ends of the operation

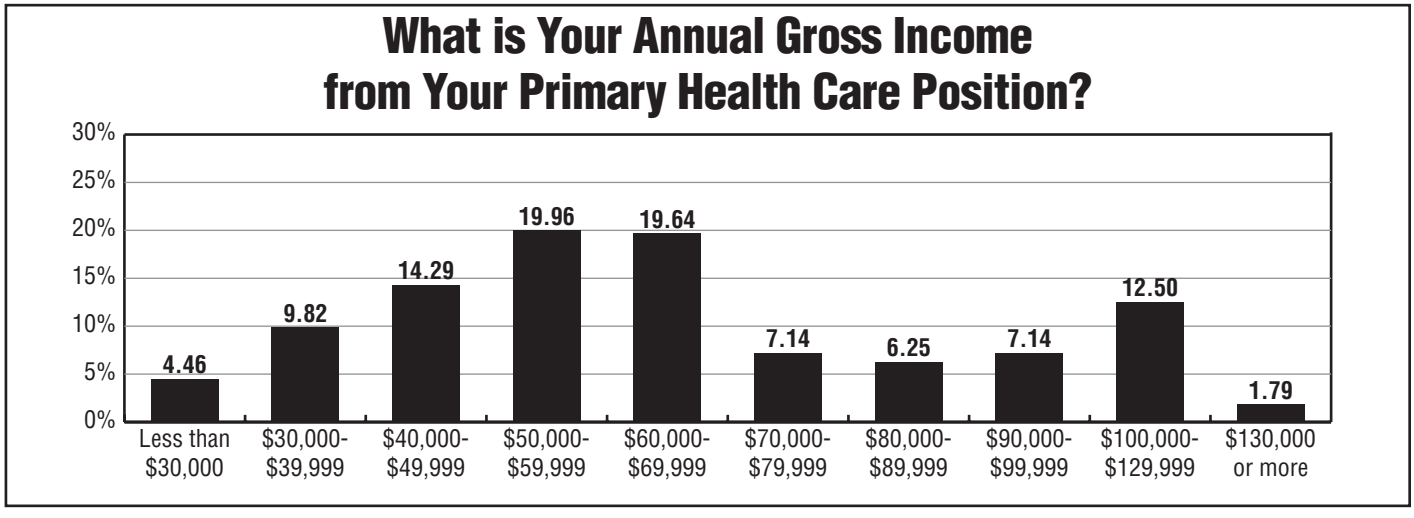
High-level positions with "revenue cycle" in the title are generating buzz in the health care access management field, and that trend won't be slowing down any time soon, industry sources tell *Hospital Access Management*.

Whether at the hospital director, corporate, or vice president level, the initiative of creating revenue cycle leaders, "while gaining strength, is in its early stages," says **Scott Sette,** CPC, owner and president of the Kensington Group, a Houston-based executive placement firm specializing in financial leadership positions in the health care industry. "We will see a lot more in the upcoming few years."

The current focus on revenue cycle leadership follows a consolidation trend in the '90s, Sette notes, in which patient accounting and patient admitting functions were consolidated under patient financial services.

"The same logic has taken the next step forward to revenue cycle [directors]," he adds, with more functions added to the mix. "Some of the areas we're seeing now, in addition to admitting and registration and billing and collections, are chargemaster and medical records. We even have done a few searches for revenue cycle directors that encompass case management."

There also are instances in which some facets of the managed care operation will report to the revenue cycle director, Sette says, as well as an increasing focus around centralized scheduling. "What the whole creation of [the revenue cycle position] has been about is having one person to effect positive



change in all areas that impact patient revenue."

At many facilities a centralized scheduling department is already under the access services umbrella, he points out, but when that is not the case, it is often one of the areas a new revenue cycle director is expected to tackle.

"One of the things we're seeing is that the revenue cycle director will be charged with establishing uniform policies and procedures for all points of access and training staff on proper protocols for registration, scheduling, and other access functions," Sette says. "The idea is that if everybody is doing things the same way, there is clean information going in, which results in clean and timely collection."

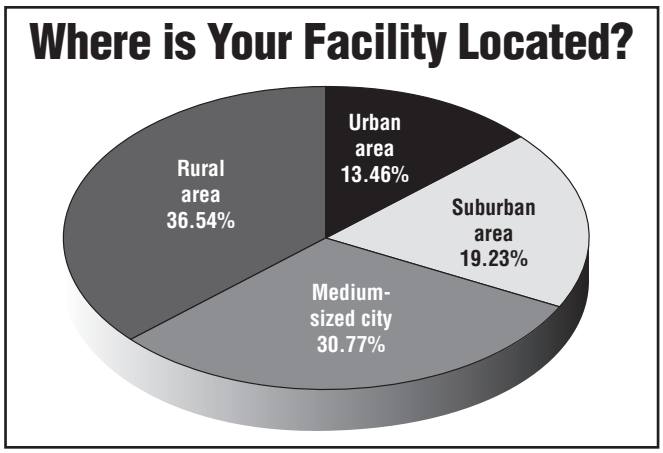
At multi-facility systems that have individual patient accounting and patient access directors for each hospital, he notes, those positions won't go away when a system vice president of revenue cycle is hired, but will work in concert with an increased initiative from the corporate level.

In such cases, Sette adds, the revenue cycle leader will make rounds to individual facilities, keeping tabs on progress, analyzing data, and making any needed adjustments. While individual facility directors may retain dotted-line reporting to the hospital CFO, he says, the trend is to have them report to a corporate vice president or director of revenue cycle.

The specific process that is put in place, of course, varies by organization, Sette emphasizes.

What **Carolyn Milburn,** president of the Dallas-based executive search firm Milburn Partners Inc., which specializes in revenue cycle positions, has observed in regard to the revenue cycle — a term that was virtually unknown a few years ago — is that its components are becoming more defined.

"What I'm seeing across the board is specialization," Milburn says, with work focused, for example, on the chargemaster or the front end or medical records. Similarly, Milburn says, if one used the term "access" just a couple of years ago, the listener — even someone in a health care field — might or might not know the intended meaning.



"We're now looking at points within the revenue cycle," she adds. "[Consultants] are saying, 'Let me come in and do an access project, as opposed to just doing a general revenue cycle analysis.'"

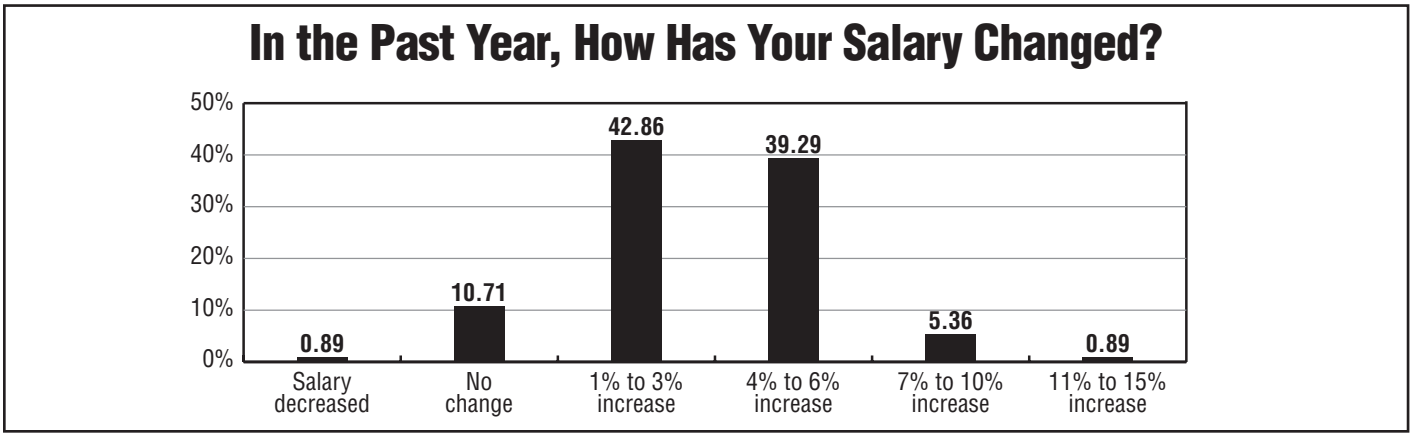
Like Sette, Milburn notes an increased interest in centralized scheduling expertise, along with more focus on customer service.

Patient access professionals interested in moving up to revenue cycle director or vice president, Sette says, should have leadership experience in both the front and back end and "have been in patient financial services for a reasonable amount of time. It's difficult to promote someone who is just [experienced] in one area."

Health care consultants, he adds, are increasingly being targeted for revenue cycle jobs because of the scope of their experience. "They might have an engagement at a community hospital and then, the next month, at a multi-hospital health system."

Sette encourages patient access directors interested in moving up the career ladder to get as wide a variety of experience as possible at their current facilities.

"Approach the CEO about more involvement in medical records or chargemaster," he says, recommending reading trade publications as much as possible and attending seminars on revenue cycle



initiatives. At the corporate and vice president level, he notes, there is more emphasis on education of all kinds, as well as advanced degrees.

The compensation that can be expected with such positions varies according to the size and type of organization, he notes. "For positions at individual facilities — revenue cycle director at a single, medium-size (200-400 beds) hospital, for example — [the salary] could be in the low $100,000s up to $125,000 or $130,000. There is bonus potential that is based on initiative in their area and the overall profitability of the organization.

"As you move into larger, multi-hospital systems — say, regional systems with four, five or six hospitals — total compensation could be $150,000 to $175,000," Sette adds. With two or three hospitals in the system, the figure might be closer to $140,000, he says. "There could be a bonus on top of that."

As for directors of patient access and patient accounting at the facility level, Sette says, there is less emphasis on education and more on experience. "Out of any of the financial leadership positions, the vast majority of the people we see who lack a four-year degree are in patient access and patient accounting. A lot of the individuals with this experience have learned through moving up the ranks and through years of service."

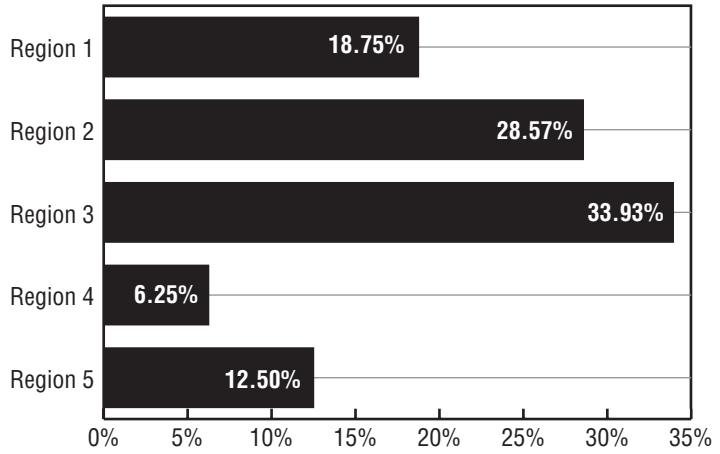
That said, he adds, "I certainly don't encourage [not getting academic degrees]." Moving into the future, Sette notes, "more and more [professionals in that category] will be getting degrees."

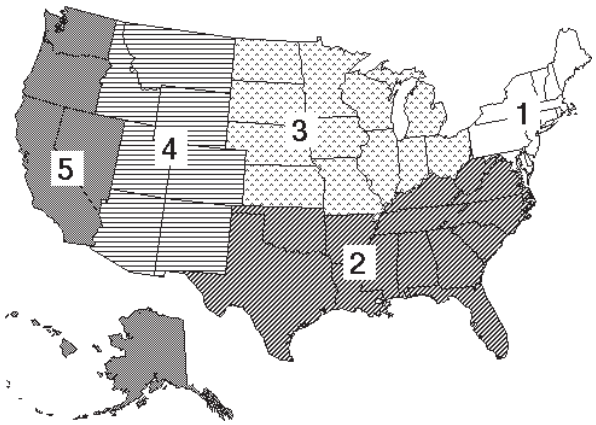
Directors of patient access and patient accounting at a medium-size hospital, he says, can expect to be paid between $85,000 and $110,000. If those individuals are over patient financial services, with a manager or assistant director of patient access or accounting reporting to them, he adds, the figure will be a little higher.

Data compiled by Milburn's firm, based on 148 professionals with director-level experience in access services at hospital systems across the country, show about a 5% increase in compensation compared to last year's figures, she notes.

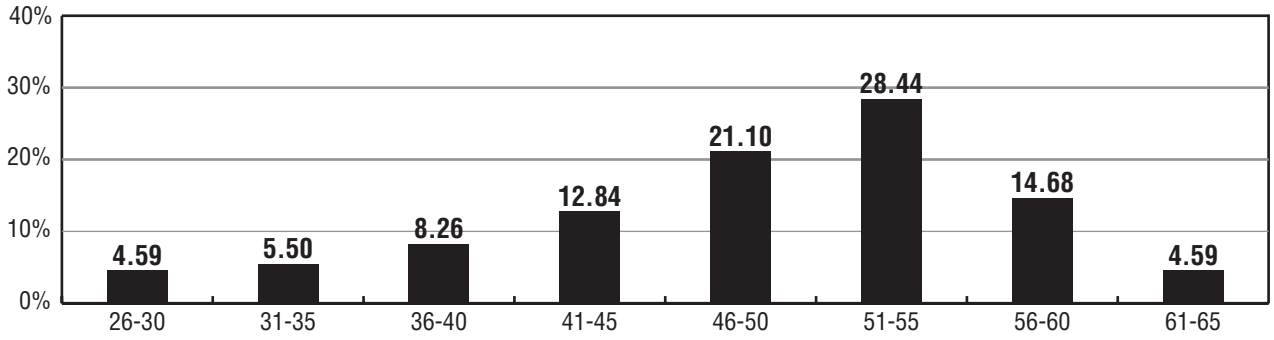
That analysis is broken down according to whether the facility is non-profit or for-profit, and by region. In the southeastern states, in which she includes Georgia, North Carolina, Florida, Tennessee, and Kentucky, the average salary for a director with more than four years' experience at a for-profit facility is $89,145, compared to $81,375 at

Where is Your Employer Located?





What is Your Age?



a non-profit facility.

In the northeast (Virginia, New Jersey, Ohio, Illinois, New York), according to her firm's data, that figure is $108,150 at a for-profit facility, and $95, 200 at a non-profit facility. In the west (California, Arizona, Colorado), the figures for that level of experience are $91,350 at a for-profit hospital, and $84,000 for a non-profit facility.

In the south, for her purposes defined as Texas, Louisiana, Mississippi, and Arkansas, comparable figures are $79,275 at a for-profit facility and $75,600 at a non-profit hospital.

Looking at the gross compensation of access professionals responding to our 2007 Salary Survey in $10,000 increments, the highest percentage (19.6%) fell into the salary range of $60,000-$69,000, followed closely by the $50,000-$59,000 (16.9%) and $40,000-$49,000 (14.3%) categories. The next most frequently selected salary range was $100,000-$129,000 (12.5%).

Overall, salaries ranged from $30,000 to $130,000, with just a few respondents reporting incomes outside either end of that range.

The figures varied only slightly from those in last year's survey, with, for example, 7% reporting income of between $90,000 and $99,000 in the 2007 survey, compared to 8% in 2006.

Again this year, the great majority (88%) of respondents reported getting a raise within the past year, with most of those divided evenly between increases of 1%-3% and increases of 4%-6%. A little more than 5% of those surveyed said they got a raise in the 7%-10% category, compared to about 9% who reported that kind of increase in the 2006 survey.

Slightly more respondents than in 2006 (10.7% compared to 8%) had no change in income during that period.

The most commonly selected job title — of five choices — was director, access management (34%), followed closely by access manager (31%). The next highest number (17.8%) chose the "other" category, and listed a variety of similar access-related titles. Those included titles that were virtually the same as the stated categories, such as director of patient access services, admitting manager, and patient registration manager.

Also listed in that group were finance-related titles such as director of revenue cycle, director of patient financial services, and business office manager, as well as those reflecting other areas of access expertise, including manager of central scheduling and central registration.

After "other," the next most frequently chosen title category was "supervisor" (14.3%), followed by "manager, patient accounts" (2.7%).

Asked to give their highest academic degree, 10.5% chose "diploma, 3-year," 9.5% selected MSA, 3.8% selected BSN, and 2.8% chose ADN.

More than 70%, however, chose "other" and mentioned a variety of degrees. By far the most often named was the BA degree, which accounted for more than three-quarters of the category. Several other types of bachelor's degrees also were included.

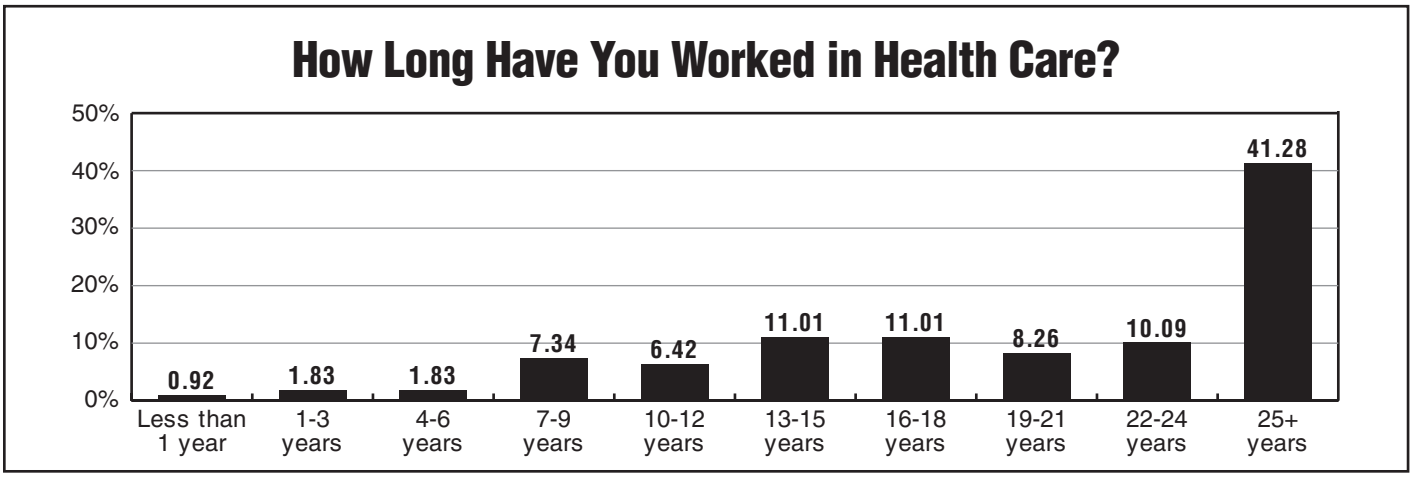
A significant number of respondents listed other master's degrees, with the MBA the most frequently named.

As usual, the vast majority work for hospitals (96.2%) and "non-profit" (91%) best describes the ownership of their employer. They are, for the most part, an experienced group, with 88% having worked in health care at least 10 years, and more than half having worked that long in their present field.

As in the 2006 survey, more respondents said they work in facilities in rural areas (36.5%) than in medium-sized cities (30.7%), suburban areas (19.2%) or urban areas (13.5%).

Most of those participating in the survey (77%) were between 41-60 years of age, with the heaviest concentration (28%) between ages 51-55.

As usual, women make up the vast majority (84%) of access professionals responding to the survey. ■



HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Should HIPAA's privacy rule be revised?

It depends on who you ask

Does the HIPAA privacy rule need to be revised to meet the needs of the current changing health care environment involving health information exchange? The answer depends on who you ask.

When the American Health Information Community's work group on confidentiality, privacy, and security held a day-long meeting to consider a "working hypothesis" that the HIPAA privacy rule, and especially its scope of coverage, is inadequate for today's health information technology needs, members heard a variety of opinions. Privacy advocates and some vendors said the rule needs to be changed, while representatives of an existing health care data exchange and a coalition of providers, drug companies, and drug distributors suggested things are fine the way they are.

The privacy rule, which was drafted in 2000 and significantly revised in 2002, does not allow patients to control use and transmission of sensitive health care information. And its protections only apply to HIPAA-covered entities — payers, providers, and claims clearinghouses.

Part of the work group's hypothesis is that there needs to be one or more "enforceable mechanisms" to ensure that privacy and security requirements are met. The group noted that the Department of Health and Human Services (HHS) Office for Civil Rights had received more than 27,000 complaints of possible HIPAA privacy rule violations through April 2007, and has not issued a single fine against a HIPAA violator.

Another element in the group's hypothesis is that any organization handling protected health information should be required to meet privacy and security criteria at least equivalent to any relevant HIPAA requirements, and that rules should apply to them directly rather than through business associate agreements with covered entities.

Some of the harshest criticism came from University of Louisville Institute for Bioethics, Health Policy, and Law Director **Mark Rothstein**, a member of the National Committee for Vital and Health Statistics.

"It is debatable whether the HIPAA statute and its privacy rule ever provided an effective framework for regulating health policy," Rothstein declares. "It is not debatable that new developments in health IT render the HIPAA privacy rule obsolete and incapable of providing meaningful health privacy protection to consumers. Consequently, a new, comprehensive regulatory approach is necessary, and Congress will need to enact new legislation to provide HHS with the statutory authority to promulgate more far-reaching regulations."

Privacy not the main focus

Rothstein contends HIPAA was drafted with claims simplification in mind and that health privacy was an afterthought. A significant concern, he says, is that tens of thousands of providers that deal with individually identifiable health information are not subject to HIPAA because they don't submit electronic claims for payment.

"A health care provider's legal obligation to protect the privacy of personal health information should not turn on whether or how the provider is paid," he says. "The harm to be avoided has nothing to do with the method of payment, and individuals' health privacy should not vary based on the irrelevant criterion of method of claims processing. Furthermore, members of the public are already confused about the extent of protection of their health information, and they should not be put in the position of relying, perhaps to their detriment, on a federal rule of limited applicability."

According to Rothstein, the privacy rule also

does not apply to many non-health care entities that routinely receive and consider information contained in individually identifiable health records, including employers, life insurers, disability insurers, long-term care insurers, financial institutions, and other public and private entities. In some instances, he says, disclosure of health information is permitted without any consent or authorization, and once information is released to an organization that is not a covered entity, HIPAA does not apply to any subsequent uses and disclosures.

Shortcomings he sees under HIPAA include: (1) the lack of coverage and enforcement of business associate arrangements; (2) individuals not being given an opportunity to opt in or opt out of a network; (3) individuals having no ability to segregate sensitive elements of their health records; (4) the lack of provisions for establishing contextual access criteria or role-based access criteria to restrict the scope of disclosures; (5) loose standards for disclosure of protected health information to law enforcement and other third-party requestors; and (6) inadequate enforcement, research, oversight, outreach, and education.

"In a real sense," Rothstein says, "the shortcomings of the HIPAA privacy rule will be magnified with the establishment of a national health information network. The foremost shortcoming of HIPAA is its limited applicability. If Congress fails to address this fundamental issue, all of the other, needed revisions of the privacy rule will be largely irrelevant. Comprehensive health information exchange demands comprehensive privacy and security protection."

'Effective privacy rule'

Taking the opposite position was Health Leadership Council President **Mary Grealy**. She says the five years of deliberations that led to the privacy rule "carefully weighed the competing interests in our extraordinarily complicated health care system… The result of these deliberations we believe to be an effective privacy rule."

She says the Health Leadership Council has chaired the Confidentiality Coalition, a broad-based group of organizations that support uniform national privacy standards. The coalition, she says, sought a rule that would strike a balance between protecting the sanctity of a patient's medical information and ensuring that necessary information is available for providing quality health care and conducting vital medical research. They also advocated for a rule with effective confidentiality safeguards that would not burden providers and patients with unnecessary paperwork or delays in treatment. "We believe that the privacy rule, to a great extent, achieved this balance and has increased consumers' confidence in the privacy of their medical records," Grealy says.

While recognizing that dialogue about health information technology and standards for the electronic transaction of health care has raised questions about the privacy and security of electronic health information in an electronic context, Grealy says it is important to remember that it was concern about the impact on patient privacy of the health system widely adopting electronic transactions that spurred the HIPAA privacy rule.

"The current HIPAA regulations are very restrictive and health care organizations like our members have taken a very conservative compliance approach in their business practices… We understand that many believe that the HIPAA privacy rule must be revised in light of electronic transfer of data and web-based access to personal health records, so that patients may trust that the system will keep their data private. We share the belief that patients' confidence in health information technology systems is of the utmost importance in order for them to be successful.

"We believe that it is vitally important that patients understand the protections contained in the HIPAA rule, so they can be confident that their records are and will be protected. We also need to do a better job informing patients and consumers how appropriate access to their health information will improve the quality of their health care and the care of future generations."

State variations could be changed

While defending HIPAA, Grealy also says it is too restrictive in that it permits "significant state variations that we believe will create serious impediments to interoperable sharing or sending of health information, particularly across state lines." She says many state laws provide for more restrictive handling of patient records for treating mental health, substance abuse, and HIV/AIDS. Also, in the original privacy rule released by HHS in 2000, patient consent was required for exchange of health care information for treatment, payment, and other health care operations. That consent provision was removed in the 2002 revision. Grealy says her council opposed the consent provision and warned that proposals to add a consent requirement for health information

exchanges "would be unnecessary and harmful."

She says that if patients are able to direct where information may flow within the health care system, "it will upset HIPAA's careful calibration designed to facilitate providers having all the necessary facts for proper diagnosis and treatment."

AHIC working group meeting information is available on-line at www.hhs.gov/healthit/ahic/confidentiality/cps_archive.html. ■

HIPAA should trump other privacy laws

Multiplicity of rules makes compliance difficult

The American Hospital Association says the multiplicity of privacy rules from local, state, and federal governments, accrediting bodies, and other organizations makes compliance difficult and can interfere with patient care. In testimony before the House Science and Technology Committee Sept. 26, HCA Inc. Senior Vice President **Noel Williams** said that simply identifying all the relevant rules can be a monumental task, let alone determining how to comply when the laws may conflict.

"A single set of privacy rules is needed to facilitate the use of IT and ensure access by health care providers to needed information at the point of care," Williams said. "Specifically, federal privacy laws as laid out in the Health Information Portability and Accountability Act should preempt state and local privacy laws."

The hearing was held to consider the need for interoperability and information security in health IT and HR 2406 sponsored by Rep. **Barton Gordon** (D-TN), the committee chairman.

Williams reported that in a survey of 1,500 hospitals, more than two-thirds said they had either fully or partially implemented electronic health records. Large, urban, and teaching hospitals were more likely to have fully implemented electronic health record systems.

She also said adoption of information technology and information sharing will increase when health information and IT applications are more standardized. Currently, she said, hospitals devote considerable staff and financial resources to creating interfaces between systems or other IT "workarounds." The problem, she testified, is a need to select a single set of standards and get consensus among healthcare stakeholders to use those standards.

Also commenting on the need for generally accepted standards was American Health Information Management Association CEO **Linda Kloss**, who noted that throughout the United States, other industries are sharing data and cutting administrative costs because they are using uniform standards.

Healthcare has not followed other industries

"This has not been the case in the past in health care," she said. "For instance, today we use standards required by HIPAA. We, therefore, adopted an X12 standard for claims, the X12-837. Unfortunately… there are now over 1,000 different instructions for the use of the X12-837 in the health care industry. If we are to achieve interoperability and use standards like other industries, this should not happen or be allowed to happen.

"The health care industry has over 1 million providers, thousands of health plans and payers, a potential consumer base of over 300 million individuals, and some 1.44 million employees offering some level of health care, along with numerous government agencies. Achieving consensus on complex standards and understanding of their uniform application is a monumental task even with shared vision."

To date, according to Kloss, the U.S. health care system has had only limited success with adopting and using standards. She said the standards chosen to be included under HIPAA were reviewed by the National Committee for Vital and Health Statistics (NCVHS), which takes considerable public comment but is not a public/private entity that engages the industry and government. The result has been a limited adoption of several of the HIPAA standards and an inconsistent use of the more common claims standard and remittance standard.

Barriers to uniform standards

Kloss discussed several barriers to uniform standards adoption, including reimbursement issues as many physicians indicate they will not even consider adoption of health information technology and standards until the Medicare and Medicaid reimbursement formulas are corrected and they are paid adequately.

Rep. Gordon opened the hearing by noting that the biggest barrier to broad implementation

of health IT systems is the lack of technical standards to support interoperability while protecting data security. "It is wasteful to start investing in technology until we know it is interoperable, as the cost to upgrade to new systems would eat up any immediate cost savings," he said.

Barton's HR 2406 would authorize the National Institute of Standards and Technology (NIST) to increase its efforts to support the integration of the health care information enterprise in the U.S. It instructs NIST to advance health IT integration while working with healthcare representatives and federal agencies to develop technical roadmaps for health IT standards. It also requires NIST to create or adopt existing technology-neutral guidelines and standards for federal agencies. ■

HIMSS backs development of interoperable ePHRs

Group says ePHRs should use HIPAA standards

The Healthcare Information Management and Systems Society (HIMSS) says it supports development of interoperable electronic personal health records (ePHR) that are interactive and use a common data set of electronic health information and e-health tools. HIMSS says it envisions ePHRs that are universally accessible and layperson comprehensible, and that may be used as a life-long tool for managing relevant health information.

"The ideal ePHR would receive data from all constituents that participate in the individual's health care allow patients or proxies to enter their own data (such as journals and diaries), and designate read-only access to the ePHR or designated portions," a HIMSS position statement says.

HIMSS says it supports ePHR applications with the following characteristics:

- provide for unique patient identification;
- allow secure access to the information contained in the ePHR;
- permit receipt of e-mail alerts that do not reveal protected health information;
- allow patient proxy to act on behalf of the patient;
- permit designation of information to be shared electronically; and
- provide technical support to ePHR constituents at all times.

Current forms of ePHRs in the market mainly involve three basic models: (1) software used by individuals to enter and maintain their personal health information; (2) web sites maintained by third parties that allow patients to enter and access their information; and (3) web sites that allow patients to view information from other applications, such as an institutional electronic health record/electronic medical record or from an application that maintains the individual's health insurance claims data.

Adopt HIPAA standards even if not covered

To the extent that an entity offering an ePHR is not a HIPAA-covered entity, or is not covered by other privacy and security laws, HIMSS encourages the entity to adopt at a minimum the privacy and security standards of HIPAA as if the organization were a covered entity.

Although there is currently a lack of universal data element standards for ePHRs, HIMSS supports development of ePHRs with this minimum data set — personal identifier, clinical summary, results/reports, histories, contact and registration information, and current and historical insurance information.

HIMSS acknowledges there are many legal barriers that impede widespread ePHR adoption and recommends development of national standards to ease burdens placed on constituents due to variances in state law and/or development of national and uniform state rules, regulations, and/or standards to address legal concerns raised by ePHRs. ■

Senators say HHS needs medical privacy office

Sens. **Edward Kennedy** (D-MA) and **Patrick Leahy** (D-VT) say they will introduce legislation to create an office within the Department of Health and Human Services to interpret and enforce medical privacy.

"In this electronic era, it is essential to safeguard the privacy of medical records while ensuring our privacy laws do not stifle the flow of information fundamental to effective health care," said Kennedy, who was a sponsor of the original HIPAA legislation. He said he is unhappy with what he called the "bizarre hodgepodge" of regulations under the law and with HHS' failure to provide "adequate guidance on what is and is not barred by the law." ■