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IN THIS ISSUE

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Managing physician orders no longer an issue at St. Louis health system

Web-based tool is 'really slick, really simple,' director says

Challenges with handling physician orders abound at most hospitals: Patients may show up without the order, leading to frustration all around and a wasted appointment time. An order coming in on a multiple-use fax machine may be buried under a pile of other faxes, nowhere to be found when the patient — soon to be disgruntled customer — arrives for her mammogram or MRI.

"If the appointment is at 7 a.m. and the physician's office doesn't open until 9, the patient is waiting a long time [to have the order present]," notes **Pam Greenberg,** MHA, network director of access management at SSM Health Care in St. Louis.

The physician office staff, meanwhile, is annoyed at being called to redo an order they know they've already sent, she adds. "Sometimes it happens a couple of times and that really irritates them."

Fortunately, such occurrences are now in the past at SSM, where a "really simple, really slick" web-based tool for processing physician orders has been in place since July 2005, Greenberg says.

With the new process, she explains, the physician's office is able to fax the order using the same number, but it comes through the web-based server and is received in a computer inbox.

"Anybody you give access to can go to the Internet and pull up [the tool] and log in," explains **Becky Kinsella,** director of registration at SSM. "They save it as a 'favorite' and then go to the inbox and click on it. You can see where the message came from, see the caller ID."

Users have the ability to link the fax numbers with physician names, she adds, so that when the message comes over, the caller ID actually reads "Dr. Smith."

The access employee opens the message, sees that it is for an MRI, and then drags and drops it into an MRI folder, Greenberg says. "Rather than hand-delivering a piece of paper that could be lost, we send that folder to the [imaging] department."

If the ancillary department somehow loses the order, the staff there

can go back in to the folder and reprint it or can call access personnel and have them reprint it, she says.

"The physician's office receives a confirmation once we receive that fax," Greenberg adds, "so if we call back and ask about [an order], we can search for it by the confirmation number or the patient name."

There is an interface with the registration system, notes Kinsella, so when someone schedules a CAT scan, for example, as soon as the reservation is put into the system, that triggers the interface with Care Ready.

"When the physician's order comes over," she explains, "whoever is processing it finds the order, gets the patient name, does a search through Care Ready, pulls up that appointment and attaches the order to the appointment.

"We have patients who come in for different things and [the program] holds the history of all their orders," Kinsella adds. "With the appointment date attached to it, you know you're picking the right one."

The twist on that, she says, is that when patients aren't scheduled and the physician just faxes over an order for lab work, it still goes into Care Ready. "Once it's interfaced [for a previous order], it's still there. You just add a visit and attach the date when the order came over."

If the patient has not been entered in the system previously, Kinsella says, staff add the name to the master person index (MPI) in Care Ready. "It's a one-way interface," she emphasizes. "Care Ready doesn't send anything back to [the registration system]. It will not add the name to that system's MPI."

By the end of 2007, seven SSM hospitals are expected to be on-line with the physician order management tool, Greenberg says, and the next step will be to bring in 17 outpatient rehab clinics, which are in the process of having registrars brought under the oversight of the access department.

"The [physician order management] process will fold right into that transition," she adds.

An upgrade planned for the beginning of 2008 will enable SSM staff to provide an on-line order form to physicians, who will be offered the option of checking the procedure or service being ordered, adding an electronic signature, and sending the form back to the hospital, Greenberg adds.

In some SSM hospitals, Care Ready also is used by members of SSM's dedicated authorization group (DAG), which calls physician offices on a daily basis to get precertification information and wait for faxes to be returned, notes Kinsella.

SSM also is preparing to expand its use of the web-based tool from orders processing to "any time we need to use a fax," Greenberg says. "When we correspond interdepartmentally — if the DAG team, for example, wants to send information to inpatient case management or vice versa — we will use the same tool.

"It's not a cookie-cutter product," she adds.

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Editorial Questions

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"You really can look around and say, 'I think I can use it for this,' and tailor it for what you need."

No capital investment required

The beauty of the tool is that it is "very inexpensive" and requires no capital investment, just operational funds, Greenberg notes. "The budget is just the ongoing monthly fee for service — no huge amount for signing up, no big equipment costs."

While other solutions exist for managing physician orders, she adds, those she has researched are more complicated and more expensive. "The capital outlay would have been $25,000 or $30,000 to get started, and then enormously more per month [than the tool SSM is using]."

Part of the reason for the high costs of other physician order management products, Greenberg says, is that they are "folded into other solutions that we didn't need or already had — and you had to buy the whole thing."

Before coming to SSM, Greenberg and Kinsella worked at a community hospital with Care Ready creator John Chen and as a result were present for the genesis of the product.

"We were trying to come up with this solution as part of a continuous quality improvement project," Greenberg recounts. "He did it in the basement of the hospital and we were his pilot, [saying], 'We want this. Now we want that.' He learned that nobody was doing this, so he ran with it."

(Editor's note: Becky Kinsella can be reached at Rebecca_Kinsella@ssmhc.com. More information on Care Ready is available at www.careready.com.) ■

Customer service drives new radiology call center

Plan is to double volume in three years

A beautifully designed, state-of-the art facility for imaging services is the centerpiece of a group of previously independent sites now being served by a new radiology call center.

The idea behind the call center — the joint venture of a New York City health system and the medical school associated with it — was to market the five sites as one entity while upgrading the technology supporting them and enhancing customer service, says **Gala Prabhu,** a New York City-based senior manager for Accenture who served as project manager.

"Some of the five different facilities had specialties," adds Prabhu. "One just did MRIs and another just ultrasound and bone density scans, and two had larger repertoires. The new facility — a spectacular space — also had a PET scan."

"We wanted to create a call center that would serve all five sites, use the staff who were already there if possible, and make sure the level of service improved 100%."

Logistical concerns were "not a big deal," she notes, as service sites are all within 10 blocks of each other. "The same physicians could have patients receiving an MRI on different streets."

When the call center was set up — in a separate, nearby location — all the schedulers who had been onsite at the five service facilities moved there, Prabhu says. As the call center startup was in conjunction with the opening of a new service site, she adds, there was no reduction in the number of full-time equivalents.

"In fact, the plan was to increase staffing, as they hope to double their volume in terms of procedures in the next three years," Prabhu says.

One of the main intentions of the project — with several sites in such close proximity — was to make sure no one seeking an appointment was turned away, she says. If someone called for an appointment at one site and found no availability, Prabhu points out, the individual could always be scheduled at another location a short distance away.

As she observed existing operations at the sites, Prabhu realized that staff tended to be focused on one service line. "There were schedulers who knew how to do mammograms, and others who did MRIs.

"In one of the areas, the level of service was horrendous," she says. "They had lost some staff and the phone was not being answered." Patients in that neighborhood expected a high level of customer service and didn't hesitate to let their dissatisfaction be known, she adds.

Once the call center was up and running, no schedulers remained at the service sites except those who handled breast biopsies, Prabhu says. "A biopsy for breast cancer is so 'high touch'

Continued on p. 137

Radiology Call Center Script

Scheduler	Patient	Alternate Comments or Actions
Thank you for calling XXX. This is _____. How may I help you?	I need to schedule a PET/CT appointment	Click on scheduling on Centricity RIS Toolbar and click on "Schedule"
I can help you with this, but before I can schedule the appointment, I need to confirm that you have a written order or prescription for the test from your doctor *(Order/Prescription/Requisition are interchangeable)*	Yes, I have a written order	*If the patient says no, ask them to please call their physician to get the written order and then call back to schedule their appointment. Let them know that w/o a written order, you are unable to schedule the test.*
What is the test that you need? Please give me the diagnosis or clinical reason for your PET. Is it going to be a: - skull base to thigh (this is the most common test for oncology); - whole body (ie. melanoma, multiple myeloma or any cancer involving an extremity or the skull); or - brain (dementia, seizure focus or tumor recurrence). This information should be written on your order.	Gives the scheduler the information	*If the patient cannot read the script they can:* *1. Fax it over to the call center for them to interpret* *2. Call their referring physician and ask them to call in the order. Let them know that once you have the order, you will get back to them to schedule their appt.* Reason for the visit is entered into the history section of Image Cast.
Does your referring MD also want a CT with contrast	No	*If patient says yes — please refer to the script PET/CT with Contrast.*
Since you are scheduling a PET/CT, I need to ask you a couple of questions: 1. Are you pregnant, breast feeding or on a fertility plan? 2. Have you had any invasive procedures in the last two days? 3. Are you having any general nuclear medicine exams? 4. Are you diabetic? If you are, we need to schedule based on how you control your diabetes.	Gives the scheduler the information	*Note: If patient says yes to any of these questions, tell them:* *1. Please inform the technologist that you are pregnant, breast feeding or on a fertility plan.* *2. If you have just had a invasive procedure, we will need to schedule your exam a few days out.* *3. If you are having a nuclear exam the same day, we would like to schedule the PET after the nuclear exam.* *4. If patient is diabetic — need to ask the following follow-up questions:* *- We will check your blood sugar prior to the exam. If your sugar is more than 200 mg/dl we will have to reschedule your exam.* *- If you are on insulin, we will give you an early morning appt, so that you can fast after midnight, then have the exam, then eat, and then take your insulin once the exam is complete OR we can give you an early afternoon appt (like 12 or 1 pm) where you can take insulin four hours prior to the appt and have a light meal.* *- If you are on oral medications, we will schedule you in the afternoon so that you can eat an early breakfast, take your medication and then fast for four hours prior to the exam.* *- All diabetic patients need to bring their medication and something to eat with them, so that they can have food and medication after their exam is completed.*

If you would like to see the entire script, see this issue of *Hospital Access Management* on-line at www.ahcmedia.com.

Continued from p. 135

that we wanted [staff in that area] to work all the way through [the process] to make sure patients felt comfortable. There is a lot of information they have to give the patient and in a call center you are not able to provide that high touch."

'Really good scripts' needed

What stood out in the course of designing the call center was the need for "really good scripts" to guide conversations with patients, Prabhu points out. "People who are coming in for a bone density scan need to be told very clearly, for example, that they can't have calcium that day. There is a very rigid protocol."

In the past, staff had learned the protocols through word of mouth, Prabhu says, and were pretty good in their own areas but not across the spectrum of services.

Her biggest and most lasting contribution to the call center, she says, was the creation of a detailed script for each service line. "I did some 35 scripts by the end of the project. Most of it was in their heads. It was just a matter of getting it on paper.

"The chairman and administrator of the radiology department wanted [the communications] for each area to be very scripted, very polite, very professional," Prabhu says. "They wanted staff to say the same thing and follow the same protocols." **(See excerpt from script, p. 136.)**

Crucial to the success of the project, she notes, was the fact that the health system had just moved to a new scheduling system that allowed staff to schedule across multiple sites.

The scheduling software, the radiology module of GE Centricity, has highly refined specifications, Prabhu says, allowing users to build in such questions for the scheduler as: Did you prep the patient? Did you tell her to bring her old [mammogram] film? Did you ask if she was breast feeding?

Because the radiology department was using digital images, rather than film, the majority of tests already were stored on-line, Prabhu notes, "so it was possible to view [images] without moving them" from place to place.

In order to create a call center of this type, she emphasizes, "you have to have the technology to support the whole idea."

Knowing preferences important

Another challenge addressed via technological innovation, Prabhu says, was that while schedulers at the individual sites had developed good relationships with the physicians they served, those relationships did not exist across the five facilities and the various specialties served by the call center.

"Before, [a scheduler at a certain site] would know Dr. X's preferences, and physicians like that," she explains. "They don't like repeating themselves. They don't want to have to tell the scheduler every time, 'I want Dr. Y to read this.'"

With the computer telephony integration software planned for the radiology call center, Prabhu says, "caller ID triggers where the call is coming from, [so the scheduler] can say, 'Oh, Dr. X, I already have Dr. Y reading your film.'"

The best example of how the system works, she notes, is the Chinese restaurant where the employee answering your call says, "Do you want your usual order?" Both are based on telephone ID, Prabhu adds, and require building a database.

While the system at the Chinese restaurant basically includes your address and last order, the radiology call center database has the answers to such questions as: Who's the office administrator? Who does the physician want the test read by? Where does he or she normally send patients?

The scheduler having this information in advance of the call "makes the physician feel absolutely fantastic," Prabhu says, "and the schedulers have less stress and no sticky notes everywhere."

A staffing initiative pushed by the radiology department chairman focuses on recruiting undergraduates who want to go to medical school to work at the call center so they could get a better understanding of what that part of the health care industry entailed, Prabhu says. His other rationale, she adds, was that if you're spending a lot on technology, you want an educated, articulate individual to go along with it.

"My concern was that you're getting 20- or 21-year-old kids who have no working experience, so we had to make sure they were very well scripted," Prabhu says. "It will be interesting to see how this would work out in the long run."

What she pointed out to the department chairman, she adds, is that opportunities for career advancement are limited for call center represen-

tatives. "They can move to another level, as a manager, or you can make sure you have incentives for them."

The quality and productivity measurements necessary to create such an incentive program involve yet another type of technology that is important to the call center operation, Prabhu notes.

Using technology such as the Nortel Telephony System, she says, call center managers can rate staff performance by measuring, for example, how many callers are waiting in the queue and how long they've been waiting, and by alerting supervisors so they can jump in and take a call when necessary.

"You need technology to support a call center," Prabhu emphasizes, "especially with highly specialized areas like radiology that have detailed prep instructions. You need the knowledge and the joint effort to build all your databases. You need to have that information supplied to schedulers so they can provide it to patients."

(Editor's note: Gala Prabhu can be reached at sumangala.prabhu@accenture.com.) ■

Uninsured patients benefit from ED referral program

Tucson center serves working poor

About 110 uninsured patients a month are being referred from a Tucson, AZ, hospital emergency department to a nearby primary care and specialty center, the result of a collaborative aimed at finding the individuals an ongoing medical home.

Between August 2006 and July 2007, there were 1,352 referrals for patients "who aren't emergencies, don't have insurance, and don't have regular medical care" from St. Mary's Hospital in Tucson to nearby St. Elizabeth's Health Center, says **Nancy Johnson,** RN, PhD(c), executive director of the health center.

Patients at St. Elizabeth's, which serves individuals who are not eligible for federal- or state-funded health care programs, are put on a sliding scale and pay whatever they can afford, Johnson notes.

The effort, which began as a pilot program, will be continued, she says, noting that of the patients referred to the health center, 252 "have established care" at St. Elizabeth's. "The definition of that is that they have actually shown up, registered, and had one appointment.

"Where the rubber meets the road is if they continue [to come to the health center] and we see that we don't have other hospitalizations," Johnson adds. "That is yet to be seen."

In addition to continuing the partnership with St. Mary's, she says, health center staff will be seeking out those in need of affordable care in other places. One of those locations, Johnson notes, is a small volunteer clinic in south Tucson called Clinica Amistad.

"There is no outpatient care of any kind in that area, so it's not easy [to get treatment] if you wake up in the morning and aren't feeling well," she says.

Clinica Amistad is run by volunteers, Johnson adds, and is open only on Monday evenings. "Seventeen to 30 people show up who have no physician, no money, no insurance.

"We started sending one of the community health workers from our center there to let people know we're here and to do health education with whoever shows up," she says. The plan was to encourage them to enroll at the center, Johnson adds, "and start getting them involved in preventive health care as well as acute care — things like flu shots and PAP smears."

The message her staff want to get across, she says, "is that we can offer services based on what they can pay." As a result, it is anticipated that the hospital ED will see fewer uninsured people who are not emergencies, and there will be fewer hospital admissions.

Key to the success of St. Elizabeth's programs, Johnson notes, is the support of Tucson physicians. "Our great blessing is that we have over 150 volunteer physicians who help us." Physicians donated care worth $750,000 during the past fiscal year, she adds, including expertise, X-rays, and use of the vascular lab, among other services.

Reluctant patients

One of the challenges center staff face in their efforts to provide care to the uninsured, she says, is the reluctance of many individuals to seek treatment — no matter how crucial — that they know they can't afford.

"We have one woman in for breast cancer treatment who had a palpable lump," Johnson

notes. "She said, 'I don't want to leave my family with a large medical bill. I'd rather leave my savings account to them.'"

St. Elizabeth's staff were able to tell the woman about funding that is available from grants and from the Komen Foundation, she says, as well as care from volunteer clinicians.

Models integrate family, neighborhood

"The projects we work with are models that integrate family and neighborhood," Johnson explains. "If I'm hanging out with people who eat healthy and take a walk every morning, I'm not as likely to eat doughnuts and lie in front of the television. A lot of people are influenced by those around them."

The Monday night sessions that St. Elizabeth's community health workers conduct at Clinica Amistad, for example, include nutrition education and chair exercise sessions "with whoever happens to be there," she says. "It's very impromptu. They might say, 'We will talk tonight about protein and where to find it, or calcium and what foods it's in.'"

Staff might start a conversation with patients about the foods they like to prepare and suggest ways to make them healthier, or discuss stress management activities, Johnson says.

"Our education is twofold," she adds. "One [approach] is to provide health information, but another is to build trust and to convince people that [St. Elizabeth's] will be a comfortable place to get care."

Cooperation between health center and hospital employees is a continuing focus, Johnson notes "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance, so they can be prepared to help rather than have it be a traumatic experience."

St. Elizabeth personnel work with hospitals to set up packages and payment plans for uninsured patients, she says, including an arrangement with Tucson's University Hospital on obstetrics care.

The health center has obtained funding to establish an electronic medical record (EMR) system, Johnson says, and it is expected to be in place by the summer of 2008.

"That will help us tremendously," she adds. "We're building in some templates for all the education and health prevention [programs] we're doing."

In the case of patients who are referred from the ED, Johnson says, "we will be able to measure the power of these interventions. We might have a diabetic who has improved — his hemoglobin A1c has gone down, which is the gold standard we use for control of diabetes."

Using the EMR, she explains, the individual would be logged in as an ED referral, with notations in the record showing that he came to the nutrition class and did the chair exercise, and that those things actually impact clinical outcomes.

"Most EMRs are designed for what happens in the exam room, and that is certainly helpful, but the premise we have is that [the traditional] model of care needs adjustment and that some of the preventive intervention may affect everything else."

Physicians will be able to pull a person's record, she adds, and say, 'Oh, I see you've been going to this exercise class.'"

"We live in a really abundant society," Johnson points out, where a lot of money is channeled toward health care. "Money is spent on treatment and hospital care. It is a disease-based model. We reimburse hospitals and specialists for surgery, radiation, and chemotherapy, but we don't have a lot of funding on the front side for prevention."

If an uninsured person feels fine, she may not see spending $75 for a mammogram. "I believe there needs to be a shift to get money on the front side and help people who are working but who can't afford to pay $1,000 a month for insurance."

(Editor's note: Nancy Johnson can be reached at njohnson@ccs-soaz.org.) ■

Specialist: Reimbursement opportunity being missed

Disability program has 'untapped potential'

Something that puzzles **Patti Thrailkill,** who spent more than 20 years working with the federal disability program, is why there isn't more energy at hospitals spent trying to get disability benefits for patients.

Several misconceptions about the program are preventing access managers and other personnel from taking advantage of "the untapped potential of Medicaid" in obtaining coverage, suggests Thrailkill, now director of governmental affairs

for MedAssist, an eligibility services vendor.

The self-pay population is particularly well served by the federal disability program, she points out, because Medicaid is one of the benefits that comes with it.

"There are misunderstandings about [the federal disability program] and it is detailed, but accessing it is not that difficult," she says. "Either the eligibility services vendor, if you outsource, will pick up the load, or the Social Security Administration [SSA] will take over once you get [the application] in motion."

While the federal government controls Medicaid and contributes most of the money, states vary in their funding, she notes. "As Medicaid programs grow, the number of those that [states] can afford to fund shrinks.

"Medicaid dollars are spread across fewer and fewer categories," Thrailkill says, "but one category that is always funded is federal disability." It is one of five or six mandatory Medicaid programs, she adds.

An area that states can fund or not, on the other hand, is retroactivity, she says. "The date of the application is used to start Medicaid, so if you don't make application at the day of admission, it won't cover the first day, which is the most expensive — but if it's retroactive, it is covered."

It is important, Thrailkill says, to make sure that staff understand the distinctions between the Supplemental Security Income (SSI) program and the Social Security Disability (SSD) program, both of which are administered by the SSA. She explains those differences as follows.

SSI benefits, she explains, are targeted to low-income aged, blind, disabled adults and some children and provide monthly income for eligible individuals. The money for SSI programs comes from general taxes, a combination of federal and state dollars. Medicaid is the health insurance program associated with SSI disability benefits. This insurance typically is available as of the date of application/service.

SSD benefit programs are for people who have worked and paid enough FICA withholding taxes to qualify. These tax dollars are collected and managed by the federal government. They are not based on financial limitations, but strictly on having accumulated benefits through paying taxes and confirmation of disability. Medicare is the health insurance program associated with SSD disability benefits, which are typically available two years after the onset of a medical condition.

Thrailkill, who frequently speaks to hospital groups that include access managers, says the extent to which her listeners comprehend the programs varies widely. "I watch the audience to see if I get a [reaction indicating] they don't understand."

Five common misconceptions, along with Thrailkill's clarifications, are listed below.

• Misconception No. 1: The SSA makes special arrangements with some companies, which creates exclusivity or preferences in working claims.

This is absolutely not true, she says. "SSA is an agent of the federal government and all federal agencies are 'equal opportunity providers.' Unilateral agreements are not legal for any federal agency, so no preferred agreement can be made with any company to grant faster, better, or easier access to SSI or SSD benefits for the clients they represent."

• Misconception No. 2: All disability applications can be made on-line.

Only SSD — not SSI — applications can be made on-line at this time, Thrailkill says. Eligibility for SSD benefits is based on taxes paid on an individual's wages, she adds, and his or her eligibility is checked electronically using a Social Security number.

SSD applications can be done on-line because eligibility is easily verifiable, Thrailkill says. Determining eligibility for SSI, on the other hand, is a manual process that involves collecting information about an individual's current income and resources, she explains, and "the potential for fraudulent reporting of income and resources is significant."

• Misconception No. 3: Patients must be represented by an attorney to get benefits.

Benefits are granted based on objective evidence submitted to the SSA and the state Disability Determination Services (DDS) office, Thrailkill says, and attorneys are not a necessary component of the process, nor are patients penalized if they do not have an attorney. The process, she adds, works like this: The SSA determines technical eligibility based on taxes paid on wages and/or income and resource levels. Once the SSA has decided the person is technically eligible for SSI, SSD, or both, the application is sent to the DDS office.

At that point, DDS determines "medical eligibility" based on medical records, age, education, and work experience/capability.

One of the questions she hears most fre-

quently, Thrailkill says, is: "Why are some patients with severe medical problems denied and others who do not have such bad conditions allowed?" The answer, she adds, usually is that those individuals do not meet the "technical requirements" for SSI or SSD.

• **Misconception No. 4: It takes two years to get a disability decision.**

In actuality, Thrailkill says, initial and reconsideration decisions — which are made by the state DDS — take an average of 120 days, although that time can be shortened dramatically with assistance from eligibility services vendors. The five decision levels in the disability application process are 1) initial decision; 2) reconsideration decision; 3) administrative law judge (ALJ) decision; 4) appeals council decision; and 5) federal court decision (usually a class action).

The national average for decisions made by administrative law judges is two years, however, and appeals council and federal court decisions average more than two years, Thrailkill adds.

• **Misconception No. 5: Administrative Law Judges make all of the allowances decisions.**

While, as mentioned before, ALJ decisions do take an average of two years, the upside, Thrailkill points out, is that those outcomes account for 29% of all allowance decisions — not 100%. DDS offices within each state make 71% of the allowance decisions.

One reason for the misconception that all allowances for the disability program come via ALJs, she notes, is that most hospital CEOs are hyperaware of the claims awaiting disposition by the ALJs because they are high-dollar cases.

"The backlog is as high as three years in some areas," Thrailkill says. "These [claims] have been denied twice and they're old. The balance keeps growing."

The SSA is very aware of the need to speed up the application process for disability claims, and is taking action in that regard, she adds. The agency is inundated, Thrailkill says, because it manages five other programs in addition to SSI and SSD.

Among other efforts to move the workload along, the SSA is trying to become paperless, she notes, and is starting with the disability program because it is the most labor-intensive.

Thrailkill urges access managers to pursue disability coverage for patients who might qualify. "In order to initiate a claim, all you have to do is make a phone call, so there is no reason not to apply.

"The more you help the patient, the quicker the process will move along," she says, advising that access staff take these steps to facilitate the claim:

• Electronically transfer medical records as often as possible.

• Provide upfront medical records on the most severely medically compromised patients.

• Provide medical records on long-term inpatients.

"Get a process in place to target these people at admission," Thrailkill advises. "It is worth it in terms of dollars."

(Editor's note: Patti Thrailkill can be reached at pthrailkill@medassistgroup.com.) ■

Admission screening for MRSA gains award

Process uses EMRs, molecular testing

One U.S. health care system is ahead of the curve when it comes to dealing with methicillin-resistant *Staphylococcus aureus* (MRSA), a difficult-to-treat strain of bacteria that is a significant cause of hospital-acquired infections.

Evanston (IL) Northwestern Healthcare, recently chosen as the 2007 recipient of the Eisenberg Patient Safety and Quality Award, began an admission screening program for MRSA more than two years ago, well before the strain became such a frequent topic in news reports.

The admission surveillance program, begun in 2005, uses the electronic medical record (EMR) and same-day molecular testing to screen patients on admission and determine if they are infected with MRSA or are colonized with the bacteria but not yet infected, explains **Lance Peterson,** MD, FASCP, epidemiologist and director of clinical microbiology and infectious disease research at Evanston Northwestern and professor of pathology and medicine at Northwestern University's Feinberg School of Medicine.

The process — the first to combine those two technologies in MRSA screening — allows physicians to immediately identify and treat patients who might otherwise be unaware of having MRSA.

That's because the EMR contains an admission

sheet as part of each patient's treatment plan that prompts the admitting team to order and collect a nasal swab before a health care provider moves to the next computer screen.

"This electronic 'red flag' ensures compliance and allows us to document cases in which a patient may refuse the test," Peterson says.

Each patient's nasal sample is tested using real-time DNA analysis. Once diagnosed, patients are treated with a nasal antibiotic ointment for five days and also need to bathe with a special antiseptic soap on the first, third, and last day of the nasal ointment treatment.

At its three hospitals, Evanston Northwestern reduced MRSA infection rates by 60% within the first year of the program.

The Eisenberg Award, sponsored by the National Quality Forum (NQF) and The Joint Commission, recognizes Evanston Northwestern for local innovation regarding patient safety.

The health system's MRSA Reduction Program Team planned to publish its findings, and members offer an outreach program to long-term care facilities to help prevent MRSA infection. ■

Placement decisions tricky for at-risk seniors

Often SNF 'safest discharge' to make

Discharge planning for the high-risk "frail senior" population is difficult at best, says **Barbara Leach,** RNC, MS, CNA, ACM, director of case management, Sacramento/Solo, with the Sutter Health Sacramento Sierra Region.

"Often the decision to send an elderly patient to a skilled nursing facility [SNF] for further recovery and evaluation is the safest discharge we can make."

Keeping people in acute hospitals for long lengths of stay is not good for many reasons, she notes. "For the elderly it is very disruptive and often leads to delirium, which puts them at risk."

Determining whether it is safe for the person to return home to be cared for by intermittent caregivers or an elderly mate is also a risky proposition, Leach adds.

"At Sutter Medical Center, we do see our elderly patients early in their stay," she says. "We collaborate with the patient, his or her family, and the care team for the best discharge plan we can."

Hospital Access Management asked Leach to comment on testimony given at a recent joint hearing of the Assembly on Aging and Long-term Care Committee and the Assembly Health Committee of the California legislature.

The hearing, which focused on the discharge plans that hospitals provide for patients, drew critical reactions from several patient advocacy groups and other organizations.

Some told the panel that as health care costs have risen, hospital stays have shortened, and patients are more and more likely to leave with inadequate after-care plans and end up back in the hospital.

Hospitals — and Medicaid regulations — were criticized for steering patients to costly institutional facilities, rather than arranging for more cost-effective home health services. ■

Call centers could help with public health crises

Report looks at leveraging resources

Leveraging the resources of established call centers to serve the public in the event of a health emergency is one of the strategies proposed in a recent report from the Agency for Healthcare Research and Quality (AHRQ).

Developed by a panel of experts, the report contains strategies and tools to help community call centers respond to caller concerns about health risks, collect disease surveillance data, sort calls according to urgency, monitor or contact people quarantined at home, and help callers identify and take dispensed drugs appropriately.

The report recommends expanding the capabilities of nurse advice lines, health agency hotlines, poison control centers, and drug information centers.

To guide call centers in adapting for emergencies, a model called the Health Emergency Line for the Public (HELP) was developed. The model, developed by Denver Health under a contract with AHRQ, uses interactive response technology to provide public information and decision support related to health events in Colorado.

A blueprint for the HELP model is provided in the AHRQ report, along with four detailed interactive response applications for the model. The applications allow callers to use their touch-tone

phones to automatically retrieve critical information during a public health emergency.

The interactive response applications are:

• A quarantine/isolation monitoring application. This application can automatically place calls to individuals in home quarantine during a disease outbreak, such as pandemic influenza, to assess their health status. The application reports on those who don't answer so that follow-up can be conducted.

• A point-of-dispensing locations application. This application can provide callers with locations for drug-dispensing sites in their county based on the caller's zip code.

• A drug identification application that can support mass prophylaxis with antibiotic drugs. This application helps callers identify dispensed drugs, provides information on how to take them, and describes potential adverse reactions.

• A library of frequently asked questions that can disseminate up-to-date, accurate, health department-approved information to the public and to health care providers. This application allows callers to navigate through a library of frequently asked questions to retrieve information relative to their concern. ■

Providers reminded NPI required beginning Jan. 1

Claims without it 'unprocessable'

Beginning Jan. 1, 2008, the Centers for Medicare & Medicaid Services (CMS) will require hospitals and other health care providers to use a National Provider Identifier when they bill Medicare fiscal intermediaries and Medicare administrative contractors, the agency said in a recent notice.

Claims that contain only a legacy provider identifier in the primary fields will be returned as "unprocessable," CMS said. The agency said it was taking "the next step toward full implementation of the NPI" because the "vast majority" of institutional providers already include the NPI on their Medicare claims.

Providers may include both an NPI and legacy identifier in the primary fields through April 2008. CMS recommends, however, that they submit at least some claims with only an NPI to ensure their claims will be processed successfully when an NPI alone is required beginning May 1, 2008.

Rejected claims, delayed reimbursement, and potentially lost reimbursement will result if hospitals don't have the proper processes in place, cautions **Beth Keith,** CHAM, senior management consultant for ACS Healthcare Solutions.

Providers should have taken the following steps, Keith says:

• Obtained NPI numbers for all required providers;

• Cleaned and corrected existing provider master files;

• Mapped a crosswalk with NPI numbers and UPIN, payer identifiers, etc., for all providers

The change affects providers' information technology systems as well as their reimbursement, Keith notes, in that current claims processing systems must accommodate the NPI identifier. ▼

ED visits up by 5.1 million according to CDC report

Visits to hospital emergency departments increased by 5.1 million in 2005 to 115.3 million, according to a recent report by the Centers for Disease Control and Prevention.

That is an average of about 30,000 visits per ED, nearly one-third more than in 1995. The ED

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visit rate for patients without health insurance was about twice that of those with private insurance, according to the report. Infants under age 1 had the highest visit rate by age. The leading diagnosis for children under 13 was acute upper respiratory infection.

Other top diagnoses by age were bruises, adolescents; abdominal pain, adults under 50; chest pain, adults 50-64; and heart disease, seniors. About 12% of ED visits resulted in hospital admission. The leading diagnosis at discharge was heart disease.

The 2008 edition of AHA Hospital Statistics, which came out in late October , includes figures regarding ED usage in 2006. It reports that hospital EDs served 3.6 million more people that year than in 2005, while the number of inpatient admissions held steady.

ED visits totaled 118.4 million, up from 88.5 million in 1991, according to the AHA survey. Contributing to the rise in visits, it reported, is the increased use of hospital services from baby boomers who recently turned 60, an age when use of health care services begins to go up dramatically. ▼

AHA survey report outlines uncompensated care costs

The cost of uncompensated hospital care in the United States was $31.2 billion in 2006, up from $28.8 billion in 2005 and $21.6 billion in 2000, according to the latest figures from the American Hospital Association's Annual Survey of Hospitals.

Underpayment by Medicare and Medicaid reached nearly $30 billion in 2006, up from 25.3 billion in 2005 and $4 billion in 2000. Medicare reimbursed 91 cents and Medicaid reimbursed 86 cents for every dollar hospitals spent caring for these patients.

In 2005, 65% of hospitals received Medicare payments less than cost and 77% of hospitals received Medicaid payments less than cost.

AHA President and CEO Rich Umbdenstock says survey data show that "hospitals are seeing more and more patients while future financing is uncertain, emergency departments continue to be overcrowded, and fewer workers are available to provide care."

The information is summarized in two AHA fact sheets, available on-line at www.aha.org. ■

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2007 Index

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