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More patient-friendly bills, improved reconciliation ongoing industry goals

Discrepancies often undetected

Making patient bills more user-friendly — not to mention ensuring that they are actually accurate — continues to be a focus in the health care industry.

One in four consumers polled by PNC Financial Services Group Inc. (www.pnc.com) said they believe their insurer had denied a legitimate claim and, of those, many reported paying the claim out of their own pocket, probably motivated by the fear of getting their credit damaged.

In the same poll, one in three Americans reported having trouble understanding the explanation of health benefits they received from their insurer.

Common billing issues

Common billing mistakes include medical-coding errors, errors in how annual deductibles are applied, and confusion about which providers are in or out of network.

One of the biggest patient billing issues is related to the need for better reconciliation between what goes onto the bill and what services are actually provided, says **Susan Johnson,** a Chicago-based senior consultant for Watson Wyatt Worldwide.

"The hard thing is that very rarely do hospitals submit detailed bills — just major revenue codes," she adds. "Drugs are ordered but never given and then the patient is discharged. Once [the drug] is ordered by the physician, it shows up on the bill even if the patient never receives it."

With the way bills are submitted now, such discrepancies aren't revealed until a hospital bill audit is conducted, Johnson points out. Providers may say it doesn't matter that care is not reimbursed at a line-by-line level — because of diagnosis-related groups (DRGs) — but she contends that the lack of detail ultimately increases health care costs.

"It looks like this many drugs, this many services [were provided], but they weren't," Johnson says, "so on an accumulated basis, it drives up rates."

Diligence is required at the front end by the staff who are putting the bill together, she notes. "[Detailed information] typically doesn't make it to the insurer or the biller — they're just [using] revenue codes, but nobody will know what's really going on until somebody digs in.

"There needs to be better reconciliation before the bill is actually generated," she adds. "The internal audit process needs to be tighter."

Johnson says she has observed during her own hospital experiences that all orders — and charges — are entered on a computer in the patient's room. Employees also should record the fact that the drug, for example, has actually been given to the patient, she adds.

With staffing shortages at most facilities, that doesn't always happen, Johnson notes. "The same thing happens with tests."

There is a similar lack of precision with physician billing, she says. "What we tend to see is that people get one code and use it for everything."

On a routine office visit, for example, staff may use the "new patient comprehensive" code, Johnson adds. "You have that code being used over and over for the same patient."

One reason might be that with frequent staff turnover, generic codes are overused because it's the "easy thing, instead of making [employees] think," she says. "You don't want to think it's intentional. The fraudulent or less ethical [explanation] is they're using maximum codes all the time to see if they will slip through."

If this "upcoding" isn't discovered — and often it is not — "the provider gets more money," Johnson notes.

On the physician side, "in terms of pure accuracy," she adds, the biggest problem is probably the lack of modifiers. With the CMS 1500 billing form, for example, "you can put as many diagnosis codes as you want, and then there are six or seven lines for charges that have to have CPT codes and on the right, an area for each charge line and which diagnosis code goes with that charge.

"You can be that specific, but a lot of providers don't submit that level of detail," Johnson says. "If you want to list a 'well woman' visit plus a secondary diagnosis code for hypertension, if it's not clear on the charge line — if that doesn't match — the claim can be denied."

User-friendly billing initiatives

The latest Patient Friendly Billing (PFB) Project report from the Healthcare Financial Management Association (HFMA), "Reconstructing Hospital Pricing Systems," is a call to action for hospital leaders to do as much as they can to achieve a rational pricing system, according to Richard L. Clarke, the organization's president and CEO.

The report describes a pricing system fraught with subsidies, hidden taxes, and conflicting incentives that is incredibly difficult for the gen-

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Editorial Questions

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eral public to understand, inhibits transparency and price comparisons, and is costly for providers and payers to administer.

Hospitals are already making improvements to support patient-friendly pricing practices, the report states, noting that 97% of respondents to an HFMA survey say they are making "some" or "significant" progress in setting discount policies for uninsured patients. Forty-one percent report progress in creating a systematic approach to establishing rational, easily accessible pricing information, and 71% report progress in ensuring staff who interact with patients understand the organization's key pricing and payment principles.

Survey respondents said the top barriers to improving hospital pricing systems include Medicare charge structures, private payer contracts, community response, and uncompensated care.

The report, available at www.patientfriendlybilling.org, offers recommendations on how hospitals can address each of these barriers, as well as principles for improving their overall payment systems.

Since 2005, HFMA has led a collaborative effort to promote patient-friendly financial communications with support from the American Hospital Association, the Medical Management Group Association, providers, and other interested parties.

State organizations are following that lead, including the Georgia Hospital Association (GHA), which is partnering with the Georgia chapter of HFMA to assist members in implementing recommendations from some of the Patient Friendly Billing reports, says **Robert Bolden,** GHA's senior director of data services.

"We've set up a billing policy work group, and are working over the next few months to provide some [implementation] strategies," Bolden notes. The impetus for the PFB project, he adds, is to "come up with ways to provide patients a better experience with the billing process."

Recommendations include such things as trying to do as much work as possible upfront to get patients qualified for any financial assistance programs that might be appropriate, Bolden says, as well as having a strong focus on collecting payment at or before the time of service.

The whole idea behind the Georgia initiative, he points out, "is not to say you need to do this, but to find ways to facilitate and educate — to make [members] aware of what the recommendations are, and to guide them in how they might remove barriers."

Limitations in computer systems, for example, might prevent hospitals from having a patient-friendly description of a treatment or procedure in the bill, Bolden says.

"If you're allowed a certain number of characters and use medical jargon, [the bill] might say 'cholecystectomy' instead of 'gallbladder removal,' which would be the patient-friendly term," he adds. "If the patient sees that on the bill, he won't know what it is."

The solution, Bolden says, might be working with the vendor community to modify systems to be more patient-friendly.

Patient focus groups have cited such billing issues as "being overwhelmed by papers," he notes. "They may get a hospital statement — not a bill yet — saying the insurance has been billed, and then later a hospital bill, and then a bill from the surgeon, the anesthesiologist, and the radiologist, and then an explanation of benefits from the insurance company."

With that many different pieces of correspondence, Bolden says, "it's easy to put it all in a drawer and forget about it."

Access implications

Emory University Hospital in Atlanta is working on a Patient Friendly Billing project, says **Peter A. Kraus,** CHAM, business analyst for patient accounts services. While mostly a patient accounts endeavor, he notes, the project has patient access implications.

Patient access staff become directly involved, Kraus points out, in the following ways:

- Notifying patients when a patient-friendly billing initiative is implemented or about to be implemented.

In addition to changes in statement formats, Kraus says, access to viewing and paying accounts on-line may be new and different for patients unless they have used the process through banking and credit card accounts.

- Getting good patient address data and formatting it correctly.

The product being used at Emory, for example, uses an address scrubber that follows United States Postal Service parameters for abbreviations and other formatting choices, he notes. "Basically, it can stop a statement with a bad address from being sent, saving us the postage. But the address must be updated."

While the address may be "bad" in the usual

sense when this happens, it could also be a matter of what words were abbreviated and how, Kraus adds. "We're not sure what the impact will be, but [the access department] has been alerted."

• Patients get to see more about their accounts than with traditional billing.

If insurance plans are entered incorrectly, misspelled, etc., patients may see the results of careless work, he says. ■

Disaster response strategies gleaned from 9-11 experience

Four planning phases identified

The traumatic events of Sept. 11, 2001, now seared into the national consciousness, were particularly up close and personal for **Michael Friedberg,** FACHE, CHAM, who was on his way to work at Jersey City Medical Center, across the river from the World Trade Center, when the hijacked planes hit the towers.

"As many people have told you, it was a beautiful fall day," recalls Friedberg, then corporate director of patient access for Liberty Health Care System. "We had a golf outing the day before."

Forty-five minutes after the planes hit, Friedberg had just stepped outside the medical center and saw the second building collapse, he says. "I saw and heard it live. It was like a movie. I heard a rumbling, saw it teeter, and then it started to come down."

Friedberg's experience that day constituted a quick course in handling the patient access implications of a disaster he describes as truly unimaginable.

"On Sept. 10, 2001, if you and I were having a conversation and I told you that two planes would be hijacked and purposefully flown into the World Trade Center, starting a massive fire, you might have believed that," says Friedberg, who is now director, patient access services, at Armanti Financial Services in Bloomfield, NJ. "But if I had said those buildings would subsequently crumble to the ground, you would have locked me up."

There were many lessons learned that day, he adds, and a number of quickly made decisions that turned out to be exactly right. In retrospect, Friedberg identified four phases of disaster planning, which he explains below:

1. Pre-event planning (the routine work everybody does on a regular basis).

The first questions to ask, Friedberg suggests, go something like this: Do you have a plan? Is the plan realistic or was it created in 1980? We live in a different world now and if your plan is more than five years old, you need to take a look at it.

Perhaps most importantly, he asks, does your plan contemplate the complete loss of communication?

As regards 9-11, Friedberg explains, the cell phone towers and the emergency medical service (EMS) radio for his hospitals' EMS service were on top of the World Trade Center. In addition, he says, television and radio stations in the vicinity were down, computers were down, and the main telephone switch building, located several blocks from the site, was out of service.

"You need to think, 'What would I do if I couldn't use the phone or the Internet, if all the beepers went down? What if the computer system gets knocked out? All hospitals have generators, but what if communication is interrupted between you and your main server?

After the 9-11 attack, New York City was closed to all traffic, Friedberg notes. "You could not get on or off the island of Manhattan. There was no vehicular traffic, so no supplies [being delivered]. What I want to emphasize is that we've all had multiple-casualty incidents, but think what it would be like if in the next hour, your facility was going to get 1,000 patients?"

With tens of thousands of people working in the World Trade Center, the potential for patients was huge, he points out, although it turned out that most of those impacted by the attack either got away or were killed.

Not knowing how long an event will last, Friedberg says, patient access directors dealing with a disaster must think about immediate issues while also considering the future.

"Designate roles for all management staff, and consider what you will do if somebody is not there," he advises. "On that day, the [access] director for Jersey City was on vacation and by the time we realized [he should come in], he couldn't get there. My number two person, the assistant corporate director, was on maternity leave. Otherwise, we could have split up [duties]."

Procedures for communication, bed place-

ment, bed overflow, alternate registration sites, and coordination with nursing should be established, Friedberg adds, as well as for getting supplies and arranging accommodations for patients' families.

2. Before the first patient arrives.

This is the point "where you know there's been a disaster and you know patients are coming and that's all you know," he says. "Estimate event magnitude. Are we getting 50 patients or 500 patients? Forget about whether you can handle them or not. That doesn't matter — you're going to get them."

Friedberg made the decision to consolidate access staff by holding over the night shift, he notes. "I did not call in the 3 p.m. to 11 p.m. shift because I was worried [the emergency situation] would go more than eight hours and I needed reliable people to cover the next shift. People burn out at some point."

The hospital canceled all elective procedures, designated acute and non-acute treatment areas and closed the emergency department, Friedberg says. "We were in an older building that had an auditorium and we made that a non-acute fast-track area. We were able to pull computers to the front of it to register patients."

"You also need to designate a waiting area for non-acute treat-and-release patients," he adds.

That area was needed to accommodate, for example, individuals who were treated for minor injuries and released, but who couldn't yet get to their homes, Friedberg says. "For somebody who worked at the World Trade Center and lived on Long Island, being in Jersey City put them 40 or 50 miles from home."

3. During the event.

One of the most useful spur-of-the-moment decisions Friedberg made on 9-11, he recalls, was to use the hospital's downtime numbers — a separate sequence of account numbers typically used when a facility's computer system is down — for all patients whose treatment was related to the attack. **(See related story, this page.)**

"It was easy to identify within the system that those patients were related to the incident," Friedberg says. "We closed the ED, but we did have a patient come in who was very sick. That child got a regular account number and every person from the Trade Center got a [downtime] number beginning with 888."

It also was important, he says, for the hospital to provide a "staff decompression area" where employees could take a moment of respite from dealing with the tragedy.

"Everyone in the New York metropolitan area knew someone who worked at the World Trade Center," Friedberg points out. "Having to focus on doing your job while the worst tragedy since Pearl Harbor is going on in your backyard is one of those things you don't think about."

The role of a patient access manager/director during a disaster is to be troubleshooter and information distributor, he notes. "I found it very important to find some positive news to give out. For example, it was election day, so there were not as many people in the buildings as there would have been on a normal day."

Rumor control — difficult enough in a hospital when there's not a disaster — is another facet of the job, Friedberg says. One notable account of the 9-11 tragedy came from a police lieutenant who came into the hospital's ED, he adds. "He told us, 'We have four planes down — two at the World Trade Center, one at the Pentagon, and

Good documentation key in disaster recovery process

Reimbursement tied to record-keeping

In the event of a disaster, advises **Michael Friedberg,** FACHE, CHAM, director, patient access services at Armanti Financial Services in Bloomfield, NJ, maintain complete and accurate records.

Careful documentation of all the patients treated at Jersey City Medical Center as a result of the Sept. 11, 2001, attack on the World Trade Center, including using the hospital's downtime account numbers for those individuals, helped the hospital recoup all of its disaster-related expenses, notes Friedberg, who at the time was corporate director of patient access for Liberty Health Care System, the hospital's parent company.

"We had the foresight, thankfully, to do patient tracking, expense tracking, to use special codes for that," he says. "We realized the feds were going to pay for it in time to capture what we needed."

While most hospitals in New Jersey received 20 cents on the dollar for disaster-related expenditures, Friedberg adds, Jersey City Medical Center got 100% reimbursement. ■

one in Pennsylvania' — but he also said there were four more planes out there, targets unknown.

"So people were wondering what could be next — the White House, the Capitol? It helps to communicate to staff as often as possible what is actually happening."

Friedberg also saw it as his duty to be the advocate and watchdog for access staff. "I had to make sure [employees] still had the ability to do their job." He suggests that the manager/director makes it a point to float between the acute and the minor treatment areas. "You want to make sure all the staff are OK, that everything is going smoothly."

The access supervisor can play a vital role in streamlining operations during a disaster, he suggests, by being responsible for employee placement and acting as a catalyst for patient throughput.

"The supervisor should make sure staff are focused on throughput, not talking to the patients about what happened to them," Friedberg advises. "I know it sounds strange, but the supervisor needs to be the cheerleader, [saying], 'Come on, we can do this, we are trained for this.'"

Supervisors also should serve as management's "eyes and ears," he says. "It was one of my supervisors who took me aside and said, 'So-and-so is freaking out,' and that was the person I pulled out of the registration line."

One of the procedures in place was for registrars to stand in a line and, as patients walked up, for an employee to accompany each person to a room and ask for demographic information, he says. "[Employees] got upset and we had to pull them out of line and calm them down. We told them to take a few minutes and then come back and do their job."

Once the patient information was obtained, Friedberg continues, staff would bring it to the person designated to do data entry — the fastest and most accurate registrar. "We didn't worry so much about insurance, but we tried to get demographics and employer information. We didn't know who was going to pay for care, but at that point it didn't matter."

In the midst of dealing with issues related to care and staffing, he notes, queries were coming in regarding patient tracking and identification.

"Every government agency wanted information," Friedberg recalls. "The fire and police departments were looking for staff; the state and the city of New York were looking for statistics so

Contamination threat should be considered

'How do you protect staff?'

While there was no real contamination threat in relation to the World Trade Center attack, it's certainly a possibility that hospital leaders should keep in mind during preparation of a disaster plan, says **Michael Friedberg,** CHAM, FACHE, director, patient access services at Armanti Financial Services in Bloomfield, NJ.

There was a debate over whether debris from the collapsed buildings might have been toxic to those who came in contact with it, "but it didn't turn out to be an issue," notes Friedberg, who at the time was corporate director of patient access for a health care system with a facility located across the river in Jersey City, NJ.

"However, [contamination] is something you would want to consider in thinking about the possibility of a similar incident," he says. "What do you do with everything that is contaminated? What if there is a nuclear attack and the first person comes in and contaminates the emergency department? How do you protect your staff?"

A study published recently in *Disaster Medicine and Public Health Preparedness* suggests training more medical personnel in burn care, pre-positioning narcotics for burn treatment, and establishing systems to track displaced citizens, who will need food, shelter, and basic medical care.

"It is imperative that cities consider the catastrophic health consequences of a nuclear attack and create plans that will account for such an extreme challenge," said lead author **Cham Dallas,** director of the Institute for Health Management and Mass Destruction Defense at the University of Georgia.

Using prediction models, the study estimates a 550-kiloton nuclear weapon — more than 40 times the power of the Hiroshima nuclear bomb — would result in 786,000 burn victims in Los Angeles and 257,579 in Houston, of which fewer than one-quarter would survive. ■

Funding cycle discourages disaster planning

The federal government spends less than $5 per person annually to help health systems and agencies prepare for a disaster, according to a recent report from PricewaterhouseCoopers.

"An annual funding cycle discourages long-term planning or development of a sustainable response infrastructure, and many hospital executives believe that the administrative costs of applying for funding are overly burdensome for the level of funding received," the report adds.

Based on surveys and interviews with stakeholders and other studies and data, the authors identify gaps in U.S. health system preparedness and suggest strategies to improve readiness at the organizational, community, and societal levels. Among other actions, the report suggests hospitals identify how they will free up capacity in a disaster, recycle supplies to extend limited quantities, and ration resources to care for those most likely to survive. ■

they could figure out what resources were needed. The state of New Jersey had to figure out how to provide resources to assist New York, but not at the expense of the care of the citizens of New Jersey."

4. After the event.

Returning to normal operations took time, he says. In addition to the calls from government agencies, which went on for more than a week, Friedberg notes, the impact on the surrounding community had to be considered

"I realized that the next day we would be inundated with phone calls and people showing up looking for loved ones," he says. "Since access ends up doing everything, I knew the telephone operators were going to send those calls to us anyway, so I volunteered us for the job."

"That was a huge thing we learned," Friedberg recalls. "You've got to consider, 'What are people going to do?'"

Although his instincts told him many people would come to the hospital looking for information, he notes, there was some resistance to the idea from the director of another department, who predicted that everyone would go to Manhattan.

The call center he created at Jersey City Medical Center became the call center for the state of New Jersey, Friedberg says. "We set up a room with computers and coordinated with the behavioral health group, which had counselors on hand so anyone who needed grief counseling or was overwhelmed had someone there to handle their concerns.

"In four days, post-9-11, we operated 24 hours a day and answered 5,000 phone calls," he notes. "In addition, we had more than 300 people come to the hospital looking for loved ones. We were the ones who had to look and say, 'I'm sorry, that person is not on the list.'"

There also were people who drove from as far as 1,000 miles away and showed up at the hospital to see if they could be of assistance, Friedberg recalls. "One guy was a dentist. He said, 'I have skills. How can I help?'"

Among hospital personnel, he says, "for the most part, all departmental barriers, all rivalries — including the idea that patient access is not an important part of the overall process — went out the window during this event. Everybody worked together."

(Editor's note: Michael Friedberg can be reached at mfriedberg@armanti.com.) ■

Automated error tracking system gets the job done

Staff gain sense of responsibility, accomplishment

As Northern Hospital of Surry County moved from one manual solution for tracking registration errors to another, **Terry Hancock,** manager of patient access and customer service, says she "kept thinking that with so much human error and emotion going into the effort to be 100% accurate, there had to be something out there that could do this automatically."

The hospital, located in Mount Airy, NC, had gone from checking all registrations to examining a percentage, and then back to doing a 100% review, she recounts. Much staff time was spent looking at registrations and sending them back to supervisors and then to representatives to be fixed and then back again, Hancock adds, and by that time, the bills had dropped.

Later, she notes, there were weekly training

classes for registrars whose accuracy average dropped below a certain percentage. "We'd go over major errors and how to avoid them, without pointing out any one person, still trying to be very sensitive.

"What we finally understood," Hancock says, "is that with the number of pieces of information to know in a busy, busy outpatient area and an unpredictable emergency department, you can't know them all.

"No one comes to work to make errors," she adds. "Everyone comes prepared to do the best they can and they still make errors. All of the encouragement and retraining in the world couldn't stop these sometimes silly errors."

Hancock, who worked in the airline industry for many years — most recently managing the customer complaint analysis area — says she knew from that experience that there must be an automated means for the hospital system to gather and process its quality assurance information.

The airline representatives, she recalls, recorded all of the customer complaints in specific coded fields in a computer system, including "what, where, when, why codes; flights; dates; and city pairs" to define the actual customer concerns.

"We then used access queries, sequel logic, and other systems to pull that information from those fields," Hancock adds. "Being able to specify captured data fields is what enabled us to analyze and drill down into massive amounts of information to create meaningful and actionable solutions."

What the hospital needed, she realized, was a system that could measure fields, take them into another system, and check for accuracy — that could scour through hundreds of registrations a week and find the errors that staff were spending so many hours on.

"You can't replace human intelligence, but with about 85% of the errors we had — tiny and big things — you could stop and at least make folks go back and look at them," she says.

Before deciding on the error tracking tool the hospital would ultimately choose, Hancock says, "we looked at four other systems that all had good points." A couple were ruled out because they didn't work in real-time, she adds, which meant that a relief employee who was on the job one day but not back again for a week couldn't correct her errors in time to make a difference.

With a real-time system, employees could fix their errors and have the benefit of immediate feedback, Hancock notes. "What I wanted wasn't a punitive grading system, but for these folks to come to work, give it their all, and feel good at the end of the day about what they had done — and for the hospital to have clean billing [upfront] rather than fixing it on the back end."

The next step — assembling all the information needed to sell hospital leadership on the idea — was the hard part, she says. The response was positive, with the revenue cycle director giving "terrific support" to the proposal, Hancock adds. "The CFO also listened and 'got it.' He understood that we were wasting the talents of at least one FTE [full-time equivalent] who could be providing excellent customer service instead of making sure all these [data] were accurate at the point of billing."

During an average month, she says, the hospital has some 3,000 "clinicals" — X-rays, laboratory tests, CT scans, and MRIs — plus another 3,300 ED registrations and about 550 day surgeries.

Ancillary physician offices use the same registration system — although their billing is handled by another group within the hospital — and account for another 2,500 transactions, Hancock notes.

"All in all, other than inpatient admits, the Meditech [registration] system does close to

10,000 registrations a month," she says, and there are between 450 and 500 inpatient admissions each month.

"That's just 'first touches,'" Hancock points out, "and that's not always where the mistakes are made. Patients can go from observation to inpatient and, after they've been here a few days, to telemetry. We also do preregistration for all scheduled clinicals and day surgeries, so to get a true idea of how much work is being done, you have to look at so much more than the number of registrations."

In the ED, for example, there is a system whereby an access representative gets basic information during triage because so many people had been leaving through the back before being registered, she adds. "So the [triage rep] 'touches' the account, but it's not done because you can't ask for payment upfront. It later goes to the 'core rep,' who is actually verifying eligibility and finding out what the copay is."

Building from the ground up

When the new automated error tracking system — a product of Miami Lakes, FL-based AHI Software called AHI QA — was finally approved and the rule-building process began, there were issues to be worked out with the back end, Hancock notes.

"We build the rules that all the different fields in Meditech hit up against, so we control what we have in our AHI system," she explains. Jessica Arrington, the access training and systems specialist, began working with a patient financial services (PFS) specialist on "what the back side thought were errors."

There were some surprises in store, Hancock notes. "They had different things they were working from that we didn't know about."

For example, when a registrar entered "Mt. Airy," the system — which compares information against a U.S. Post Office database — read it as an error because the post office uses "Mount Airy," she says. "So PFS staff were fixing that."

Linking PFS and access

"We learned so much from each other," Hancock adds. "[The process] created such synergy between patient access and PFS." While the two departments, both of which report to the director of revenue cycle performance, already had a good relationship, one didn't really understand what was going on with the other, she notes.

"Now [access and PFS] communicate on a daily basis and the rapport that has built up is a good, good working relationship."

The error tracking system was implemented in mid-September 2007, Hancock says, and within two months, the first training class for access representatives had been held. "We're going to do two classes, because the first time you're trained, you don't know what you want to ask."

'Pop-ups' signal errors

Staff began to be excited about the process and competitive with their colleagues, she adds. "They feel good because they are seeing [the mistakes] and then fixing them.

"It's so simple for the registrar," Hancock says. "There's a pop-up that tells you everything that might be an error and typically also tells you how to fix it. That is all the end user sees. It will say, 'Excuse me, you don't have insurance in here,' but if the person [touching the account] is doing preregistration, she can't get that yet."

The system fosters teamwork, she points out. It offers "options as to whether you want the person creating the account to be the only one responsible or if you want everyone who touches the account to be responsible."

At her facility, the decision was made to have staff share responsibility. "Before, if a patient came in who was preregistered, the assumption was that [the information] must be right. Now [the pop-up] says the insurance information is not correct and they know they are [also] responsible. If no one fixes it, each of those [touches] is an error."

"The bottom line for me is to get it right the first time," Hancock notes. One registrar asked, "What if I'm always fixing somebody's errors," she adds, but explains that such occurrences would be evident to management because of all the reports on the back end that front-line employees don't see.

Those reports, Hancock says, "tell us which one has the most errors, who fixed the error. It also gave [staff] the option to let us know about an error and have us look at it."

When employees are in a hurry and work on through the pop-ups that alert them to errors, she explains, there is a worksheet they can pull up at

the end of the day that gives them all of the error information and a list of warnings.

For example, if the registrar enters a clinical procedure and a day surgery for the same day, the system asks, "Are you sure this is not a duplicate?"

The AHI system "is not in your face all day," she notes. "It runs in tandem with the Meditech system, but doesn't feed back. It only flows out."

There is also a "dispute feature" that allows staff to challenge a case in which something is almost always wrong, but not in this instance, Hancock says. "We live in the corner of North Carolina and Virginia, so some patients have a home phone with a Virginia prefix, but a cell phone with a North Carolina prefix."

When the system, noting a Virginia address, says the cell phone number is not correct, the registrar can click the dispute button. "That comes back to Jessica as the one who is managing those disputes. She sees it, accepts it, and lets it go through.

"If someone disputes something they believe is correct, she can deny that dispute and give feedback to the person on why it is not disputable," Hancock says. There is an additional training opportunity if, for example, the registrar says that it was another employee who told her the information was correct.

"[The system] is doing the things I really want it to do," she notes. It can report errors by representative, by department, and by hour in the ED, Hancock adds, but also gives registrars a sense of responsibility and accomplishment.

If a mistake is fixed within 32 hours — which is prior to billing — it does not become an error, she says. "If we set too short a time, it would become an error before [staff] had time to dispute.

"We are still finding [issues] with the rules we built, but we are learning how to write more," Hancock points out, as when Arrington refined a rule associated with a Blue Cross Blue Shield insurance identification number to make it more specific regarding dependents and whether the insurance is primary, secondary or tertiary.

"The [information] can be very detailed on the back end, but we can write something that is very simple for the rep," she says.

(Editor's note: Terry Hancock can be reached at thancock@nhsc.org.) ■

'Tremendous need' filled by ED advocate position

Nursing skills add important dimension

When **Cassandra Pundt,** RN, CEN, decided to "ratchet down" from her demanding job as emergency department nursing manager at St. Mary's Hospital in Tucson, AZ, she created a position for herself that made use of her nursing skills and filled a void in the ED operation.

During her 10 years as ED nursing manager, Pundt adds, she was constantly struck by the "tremendous need" for a patient advocate specifically dedicated to the ED.

"Because of the hotbed [of activity] that we are, there are real bottlenecks," she says. "There is so much anger and distress when patients have to wait. Sometimes when the admit beds are full, there can be up to a two-day wait for a bed. There can be ICU patients in the ED [waiting for admission]."

The demand for ED services is worse in different parts of the country, Pundt notes, "and in Arizona, in particular, there is a pretty big problem."

As ED nursing manager, she received referrals from the hospital's patient advocate, she says, "but sometimes other things get a higher priority than patient complaints" and she and the two assistant managers were unable to follow up as thoroughly as they would have liked.

Pundt, who also has worked as a cardiac nurse, believes her nursing background adds an important dimension to the advocacy role.

"Many places have advocates, but they're not nurses," she says. "That's fine, but with the critical thinking skills of a nurse, you can work through a lot more trouble-shooting — especially if there is a quality-of-care issue. I do chart reviews and pick up on things I might refer to other departments, such as risk management."

Concerned about the need for patient advocacy in the ED, Pundt wrote a job description and talked to her superiors at the hospital, who accepted her proposal. She began her job as emergency services patient representative in August 2006.

In addition to her desire to leave management because she was planning to retire in a couple of years, Pundt says, she was attracted to the idea

of having more time to spend on patient concerns. "As much as I hate to hear complaints, it's nice to get involved indirectly and address the issues."

As part of her job, Pundt teaches customer service classes to staff, she says, focusing on "how to deal with difficult patients, difficult situations — all the things you want people to demonstrate as professionals."

"We also created a bereavement support group, and follow up with patients who have lost a loved one," Pundt says. "We deal with them at the time, offering support and giving them a nice packet of information about the grieving process, and then send a sympathy card from the department."

A few weeks later, she notes, Pundt makes a phone call to the family members who have experienced a loss.

"We've had a very positive reaction," she adds. "People are very appreciative. I got a thank-you card from a family thanking me for sending them a card."

[Editor's note: Cassandra Pundt can be reached at cpundt@carondelet.org. Look for an article on a new customer service recovery program at St. Mary's Hospital in the next issue of Hospital Access Management*.]* ■

MA hospitals adopt error-related bill policy

In early 2008, Massachusetts hospitals will adopt a uniform policy not to charge patients or insurers for certain rare but serious adverse events, the Massachusetts Hospital Association announced recently.

The policy initially will cover nine preventable events from the National Quality Forum's list of serious reportable events and be expanded with experience, MHA said.

The events are surgery on a wrong body part or patient, wrong surgical procedure, retention of foreign object, medication error injury, incompatible blood-associated injury, air embolism-associated injury, artificial insemination/wrong donor, and infant discharged to wrong family.

Many hospitals already follow such a policy, the organization notes. Minnesota hospitals announced a similar statewide policy in September 2007. ▼

Uncompensated care up $2.4 billion in 2006

The cost of uncompensated care in the United States totaled $31.2 billion in 2006, up from $28.8 billion in 2005 and $21.6 billion in 2000, according to the latest data 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.

The data are summarized in two AHA fact sheets, available online at www.aha.org. ▼

On-call coverage gap hurts hospitals, patients

Physician specialists are increasingly reluctant to provide emergency on-call coverage at

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hospitals, which results in higher costs for hospitals and reduced access to specialist care for patients, according to a study in 12 communities by the Center for Studying Health System Change.

Many specialists are shifting their services to non-hospital settings or specialty hospitals, believe payment for emergency care is inadequate, have medical liability concerns with ED coverage, or view it as a burden, the authors said.

To deal with the problem, hospitals are paying for on-call coverage, physicians' malpractice premiums and treatment of uninsured patients while on call, directly employing specialist physicians, and pursuing other administrative arrangements to encourage physicians to take ED call, the study found. ▼

Smaller jump expected in health benefits costs

Employer costs for health benefits rose 6.1% in 2007 to an average of $7,983 per employee, according to a national survey by benefit consultant Mercer.

Employers expect a smaller increase of 5.7% in 2008 after anticipated changes in plans and benefits, the survey found.

Mercer attributes smaller increases in employer costs since the early 2000s in part to increased cost shifting to employees. For example, average in-network deductibles for Preferred Provider Organizations rose about 11% in 2007 among larger employers (those with 500 or more workers), Mercer said. About 80% of large employers used health management programs as another way to control costs.

The share of employers with fewer than 200 workers offering health coverage continued to decline, to 61% in 2007 from 63% in 2006. The share of all employees enrolled in a health savings account or health reimbursement account rose to 5% from 3%. Most of the newer plans were HSAs, which don't require an employer contribution. ■