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Call centers have key role to play in pandemic planning

Non-clinical staff would handle 'education' calls

Call centers will be the first line of defense for the hospitals they serve if a pandemic — such as an outbreak of avian flu — should hit the United States, say a variety of health care professionals working to prepare for such an eventuality.

The message to patient access directors and other hospital leaders is "your phones will be crazy" if a pandemic occurs, says **Pat Pollert**, RN, call center manager for MeritCare Ask-A-Nurse in Fargo, ND. "If there isn't an existing call center, [people] will call the hospital switchboard and clinics.

"You need to anticipate that and make sure you are involved in any community discussion," adds Pollert, whose call center works with the state health department to identify spikes in symptoms that could give early warning of a pandemic.

"You need to know what the plan is, because if you're not informed you could make things worse," she points out. "It may not be the best time to say, 'Just go to the emergency department,' because that could make someone sicker. If people are not experiencing flu symptoms, you don't want them exposed."

For those on the non-clinical side of this kind of disaster, says Pollert, one of the most crucial things to remember is that everyone in the organization should be providing consistent information to the public.

"[Inquiries] will be coming in through lots of different phone numbers," she notes. "Whatever the entry point, there must be the same message." In some cases, Pollert adds, the best plan will be to simply funnel calls to a central pandemic call center.

"In a true pandemic, the message going out could change by the hour," she says. "That's when you need the least number of people possible relaying that message."

It's important in a pandemic to try to isolate the caller's problem, Pollert says, "and call centers are involved because you don't want people to present on their own. There could be mandated quarantines, so the phone link is critical."

North Dakota's health department established 15 work groups to facilitate its pandemic planning, covering such topics as logistics, finance, security, and patient care. Pollert served on the patient care subgroup, which looked at, among other things, how call volumes would increase as people started getting sick and what the triggers would be for taking various steps.

"When we get X number of calls, we would bump up to this level [of response], we would set up a dedicated line at this point," she says. As patient volume increases, Pollert explains, the criteria for directing people to come in for care would get tougher.

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Editorial Questions

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"Unless people are exhibiting [a specified] group of symptoms, we want them to stay home," she adds. "We even worked out what places in the hospital people with different sets of symptoms would be directed to — based on acuity level and on what the capacity is at the moment."

Through the McKesson software used at the call center Pollert manages, data sought by the state health department are compiled seamlessly, she notes, "as our nurses go through the day and do their work."

"There may be certain symptoms the [callers] say they have, and we [select] those, providing automatic documentation," Pollert explains. At the end of the day, using a program created by the software vendor's technicians, she says, "somebody downloads the information, takes out the patient identifiers, and dumps [the data] into syndrome surveillance software."

"It's all done in terms of how the software is programmed," Pollert adds. "Say 'fever and vomiting' or 'fever and cough and abdominal pain' are the groups of symptoms we're looking for. [Technicians] are able to extract that."

Health officials have been able to correlate spikes in certain clusters of symptoms with confirmed cases of influenza, she says. "The report of the clinical data we are able to pull out of our software is a very good early predictor of potential outbreaks."

Typically, ZIP codes are included in the data in order to look for clustering, but information identifying patients is removed, Pollert says. However, she adds, if a cluster indicative of, say, an anthrax outbreak, were identified, technicians could "drill down" to that level of specificity in the interest of public safety.

Proactive approach taken

Evergreen Healthline, a 24-hour nurse and information call center at Evergreen Hospital in Kirkland, WA, became actively engaged in emergency preparedness several years ago, says call center manager **Vickie Cundy,** RNC, realizing that "we are going to be the front line for information" should a pandemic occur.

"We have a plan specific to our department as well as being involved with the emergency planning groups for the entire organization," she adds. "We also became involved with the community in a variety of breakout groups formed by the local health department's coalition for pandemic awareness."

A regional telecommunication group, started about a year ago, Cundy says, is addressing such

issues as how call centers would access the resources of their counterparts in the area "if we need to quadruple our call volume."

There are plans in place for having Evergreen call center staff handle low-level 911 calls in the event of a pandemic, she notes. "If a large part of the community is ill in a pandemic, emergency response services will be totally overwhelmed, so they are determining how to delegate the non-emergent calls to us."

Taking education calls

Under the Healthline's own departmental pandemic plan, the call center's clinical staff would continue to take triage calls from people who are symptomatic while non-clinical employees would be called upon to handle "education" calls, Cundy says.

"If people are calling and saying, 'I've heard about avian flu. What should I know?'" she adds, non-clinical staff — using scripted material — would inform callers of what to do under various circumstances.

In addition to clinical functions such as a 24-hour nurse triage line and after-hours coverage for physician clinics, Evergreen call center staff perform non-clinical tasks including scheduling diagnostic imaging and respiratory therapy procedures, physician referrals, registration for community education classes, and absence reporting (employee sick calls), Cundy notes.

"Our call center is one of the key communication links for any event that occurs at the hospital," she says. "Once the primary event team makes the decision to declare an emergency or another internal or external event with the potential to disrupt daily operations, they notify us."

The call center recently has taken responsibility for an organization-wide phone tree that covers a variety of in-house and off-campus departments it is charged with notifying in case of an event, Cundy says. "There are overhead announcements, but some staff that are off-campus don't hear. The hospital-owned clinics, for example, also need prompt notification."

The effectiveness of the phone tree has been confirmed, she notes, through two recent practice scenarios — one a region-wide test. "We didn't have 24-7 notification of all key staff and departments, and since the Healthline call center is a 24-7 operation, we realized we could support this effort effectively."

There is also a Healthline department-specific phone tree, she says, that lists all employees and the distance of their homes from the hospital — whether 15, 30, or 45 minutes away. "That allows us to quickly ramp up our staffing based on the

'Linked network' in planning stages

Technology 'looks promising'

Business-oriented, non-clinical call centers — such as those under the direction of many in the patient access field — will be an important component of the response to a large-scale public health emergency, suggests **Joe Cropley,** project manager for the Puget Sound Call Center Coordination Project.

Such call centers "might be called to participate in a linked network" should a pandemic or similar situation arise, says Cropley, who is employed by the Washington Poison Center, which is under contract to Seattle-King County Public Health.

That region, he adds, "is the only one in the country right now actively trying to put something together" in terms of a call center network for public health emergencies.

While one component of the planned call center response will be medical triage, he says, the other — in which non-clinical centers will be involved — "will be what we are calling 'the provision of scripted general health information.'"

For those concerned because their facilities use proprietary software and might not be able to connect with a network of call centers, Cropley notes that a variety of technologies that would take care of that issue are being explored. "It looks promising," he adds.

Cropley says he welcomes feedback from health care professionals interested in working toward this kind of call center solution in their own areas.

Non-clinical call centers' participation in such a network would be activated only in the event of a widespread public emergency such as a pandemic, he emphasizes. "This would not be day-to-day business."

The goal, as others have pointed out, will be "to keep as many people at home as possible" and provide relief to hospitals, clinics, and 911 services that are being overwhelmed by calls, he says.

*(Editor's note: **Joe Cropley** can be reached at cropley@wapc.org.)* ■

employee's proximity to our worksite.

"We have also shared what our department did to educate our team on pandemic [preparedness] with the organization's planning team," Cundy adds. "They decided there was a need for an education tool for the entire organization."

Other departments have asked for copies of the call center plan, Cundy says, in order to develop something similar.

A learning tool containing emergency preparedness information is in development for organization-wide continuing education use that shows employees how to be prepared at home in the event of a disaster or pandemic. "If they're prepared at home, they're more willing to come to work," Cundy says.

Remote work force deployed

One of the primary components of the call center's emergency preparedness program, she continues, is a remote force of employees who are able to work entirely from their homes with full access to the call center's software system.

The development of a remote work force began three years ago with a small group, Cundy explains, and now several employees participate.

Initially, land lines were installed in four user homes, and those employees could make outbound calls for the center, she adds. The recent advent of Voice over Internet Phone (VoIP) technology, however, now allows home-based staff to handle both incoming and outbound calls, Cundy says, which greatly increases call efficiency.

"Our department also has back-up plans on how to rapidly mobilize additional remote staff if necessary," she notes "In addition, arrangements have been made for ramping up the call center's software licensing to handle one-, two- or three-month high-volume scenarios should a pandemic occur."

As the severity of a pandemic increased, call centers would go from providing information and referrals to also having their own level of preparedness, notes **Marlene Grasser,** RN, a Seattle-based regional sales director for contact center software vendor LVM Systems, of Mesa, AZ.

"The function would start to change," adds Grasser, a former call center manager who spent 20 years working for Evergreen Healthline, and would include such steps as beginning to screen call center employees and keep records of those results.

Services available at the hospital would gradually be reduced as the pandemic level goes higher, she suggests, and there would be occurrences such as, for example, running out of ventilators. In those instances, Grasser says, the call center would begin referring people to surrounding clinics and trying to keep the ED volume as low as possible.

"There would be designated fever clinics, sick clinics, and immunization clinics," she notes. Schools and other facilities would not be operating and would be used to provide patient care, Grasser says. "The call center would be tracking information [to identify] resources in the community and delegate people to those facilities."

At Evergreen's call center, notes Cundy, there will be a screening process for any employees entering the work site during a pandemic. The person's temperature will be taken, and an assessment will be done to determine whether any family member at home is sick with symptoms of avian flu, she adds. "If so, the employee will not be allowed in the call center.

"We have masks and food preparation [capabilities] so people can stay on-site if necessary," Cundy says. "During a pandemic we can expect to be working long hours so being prepared at the call center and at home is essential. Because our software is complex, it would be difficult to bring in outside people to do triage, which is why a remote user staff is advantageous in emergency planning."

To patient access directors and others who might face this kind of health care crisis, Grasser says, "the best thing I can say is to network. Every demographic area has different needs, different issues. For example, we estimate the pandemic will hit where birds migrate — not the Midwest, but coastal areas — so network with others in that

National Response Framework replaces earlier DHS plan

The Department of Homeland Security has released a National Response Framework (NRF), which replaces the National Response Plan as a guide to government and private sector roles, responsibilities, and relationships in emergency planning, preparedness and response.

DHS said the framework is a response to repeated requests for a more streamlined, user-friendly document. In addition to the base document, it includes numerous annexes dealing with issues ranging from public health and medical services to private sector coordination and communications. ■

demographic, or in the 'opposite' areas, which might bring up things you haven't considered."

Evergreen call center personnel had conversations with their counterparts in Nevada, she notes, on how to use software differently to maximize its usefulness.

"Not everyone can be fully prepared, so know how to deal with excessive volume, know how to refer out," Grasser advises. "Things in the software area are constantly changing. Be as automated as possible. Be able to send blast e-mails and blast faxes.

"You don't want your staff to have to stop and think about where to go for information," she says. "Make it easier for them [with] automated pop-ups. Make sure the software fits the process and not the other way around."

When U.S. health officials speak of a pandemic, Grasser notes, they're talking about the potential outbreak of a very aggressive influenza virus with the markers H5N1 or some mutation of that virus.

"There is human-to-human transmission, but [the virus] is not spread rapidly," she notes. "It is predicted that it will in the future. When we see that virus pop up, that is when our level of alertness goes up. The virus just needs to mutate a little and we would have a major pandemic."

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Script 'introducing' DPs aids in 'Message' delivery

Two audits also part of process

Two new auditing processes and a script for "introducing" discharge planners to their patients are the latest innovations at Stevens Hospital in Edmunds, WA, part of its response to the revised "Important Message from Medicare" (IM).

The hospital's program to turn the new requirements into a way to market its discharge planning services to patients has had excellent results, says **Mary Bea Gallagher,** a Seattle-based senior consultant with ACS Healthcare Solutions who recently completed a stint as director of case management at the facility. **(See related article in the October 2007 issue of *Hospital Access Management*.)**

Not only did an anticipated increase in discharge appeals not materialize, Gallagher notes, the hospital's customer service initiatives have received positive feedback from patients and tools put in place to aid the process have had unexpected side benefits.

"To date, we have had two appeals, both of which failed and both of which were instituted by families and not supported by the patients," she says.

The revised IM — which must be signed by the patient and presented upon discharge as well as upon admission — explains that patients have the right to appeal if they believe they are being discharged too soon and gives the phone number of the hospital's regional quality improvement organization (QIO).

In both instances in which discharges were appealed at Stevens Hospital, Gallagher notes, the impetus came not from the patient but from family members and had more to do with family scheduling issues than with concerns about the patient's readiness to be released.

In one case, she says, the patient's son called and said the hospital couldn't send his elderly father home because the family was at a resort on Puget Sound over the Thanksgiving holiday. Not only would they not be there to care for the patient, but they also couldn't look at skilled nursing facilities (SNFs), Gallagher adds. "They gave that as the reason [for the appeal].

"Another case was similar," she recalls. "The [patient's] daughter said, 'If I take Mom home now, I don't know what I will do with her on Thursday because I have to go on a business trip.'"

At that point, Gallagher says, the woman had not been in the hospital the required length of time to qualify for placement in an SNF, so the daughter wanted her to remain an inpatient long enough to qualify. The patient, she notes, was saying, "Please, can I go home?"

Days spent in the hospital awaiting the outcome of an appeal do not go toward meeting the SNF requirement, but the Medicare fiscal intermediary does not have a tracking mechanism in place that makes that distinction, Gallagher points out, "and the woman was smart enough to figure that out."

Regarding the patient who needed to be discharged during the Thanksgiving holiday: When the son was told that his father didn't medically qualify to stay in the hospital, she adds, "his answer was, 'I'm an attorney.'"

Although QIOs are looking at appeals from the patient's standpoint and even then finding very

few that hold up, Gallagher says, hospitals still must deal with "people who know how to game the system" as well as huge expenses resulting from the appeals.

The word from the Centers for Medicare & Medicaid Services (CMS), she notes, is that "nothing can change in less than three years. So it comes back to the hospital to figure out how to reduce the number of appeals."

Hospitals are left with little recourse, Gallagher says, "other than tactics like ours such as selling the discharge planning process and [creating] a happy discharge plan."

One of the reasons the new "sales pitch" for discharge planners at Stevens Hospital is working, she suggests, is that it addresses certain patient concerns earlier in the hospital stay.

"We picked up from the questions that patients were asking that there was a sense of anxiety around the need to look for an SNF [and other discharge-related issues], especially if the family was far away," Gallagher adds.

While these concerns don't typically come up during admission, when patients "are just signing anything they can" to complete that process, she says, they often surface after the patient has been in the hospital a couple of days and has had time to settle in.

"Patients have had time to recover and think, 'Who will help me with discharge planning?' It may be that they haven't met the discharge planner yet."

Under the new procedure, Gallagher explains, discharge planners write an introduction containing information about themselves they want the patient to know. That document is used as a script by case management assistants who deliver the discharge notice, she adds.

In some cases, there are nurses who work with the discharge planners as a team, Gallagher notes, so an individual might write an introduction for herself and one for her team member.

"This provides a resource that gives the case

New CM assistants hired for customer service savvy

'We got more than we bargained for'

When Stevens Hospital in Edmonds, WA, decided to hire people at a clerical skill level to distribute the Important Message From Medicare — allowing social workers to keep their focus on discharge planning — the initial idea was to get those employees from the medical records department and train them to do the job, says **Mary Bea Gallagher,** a Seattle-based senior consultant with ACS Healthcare Solutions.

"That didn't work," adds Gallagher, who says she knew within a week that the individuals with medical records experience were not suited for the task.

"Because they were not hired for their customer service skills, they were not as likely to walk in with a smile," she notes. "When they started to stumble, I stepped in. I knew we had to hire for customer service skills and then teach them the other side of the business."

The new case management assistants — two part-time employees representing one full-time equivalent — had to learn medical terminology and abbreviations, for example, in order to be comfortable sitting in on the morning and weekend interdisciplinary huddles that take place, explains Gallagher, who recently ended her tenure as the hospital's interim director of case management.

The employees also became certified as medical notaries, she says, thus providing a service formerly available only during regular business hours at the hospital's central office.

The case management assistants work about five hours on weekdays and closer to seven hours on weekends, Gallagher says. "We got more than we bargained for — weekend and holiday coverage for forms [distribution] and clerical support that we didn't have before. During the weekend, we have double coverage for the busiest part of the day.

"Hiring them for customer service skills was one of the best decisions we made, even though we have to train them on medical terms," she adds. "That is a huge [contributor] to the fact that our patients are very happy."

One piece of the Important Message initiative was not yet in place, Gallagher notes, because of the need to fill some social worker positions.

"We plan to make follow-up calls to patients after discharge to make sure that the home health nurse showed up, that the physical therapist started as scheduled, and to check on whether patients are as happy [with the discharge plan] as we thought they were," she says. "If not, we will follow up to make sure the complaint is resolved.

"If you do discharge planning but don't follow up, you don't know how good it is," Gallagher adds. "You only think it's good." ■

management assistant a ready answer and has been very valuable in reducing anxiety," she says. The script might, for example, go as follows.

"Marlene Higgins is your discharge planner. She has been with the Stevens Hospital social work department for 17 years. She has a lot of valuable community contacts and has helped more than 7,000 people with their discharge planning. I know you will appreciate her understanding and skill."

The assistant may add that if the patient likes she will be happy to print a digital photograph of the discharge planner, "but she will be in to see you within the next 48 hours so you will meet her then," Gallagher says.

The introductions — instituted in November 2007 — have been very effective not only with "selling" the discharge planning process, but in assuring patients that it's going to happen, she notes, although the discharge planning staff didn't see the advantage at first.

"They said, 'Why don't you just pass out our business cards?' We kind of forced them into it, saying, 'The case management assistants can't sell you if they don't know how long you've been here, how many patients you've helped, and what your biggest asset is.'"

Armed with the information, patients already are sold on the discharge planner when she walks in the door, Gallagher says. "Patients don't normally ask about you when you're standing in front of them, but they will ask someone else about you."

'Delivery components' reviewed

Another tool implemented in recent weeks to streamline the delivery of the IM at Stevens Hospital is an audit process, begun in September 2007, that examines all the components that make up the delivery of the form.

Components that are reviewed include not only signature and date, Gallagher says, but whether the patient's name is legible and whether the physician's name and the account number are on the form. The audit also addresses issues that often require a lot of time to chase down, she adds, such as: "If the patient was not available, did you contact the next of kin or the person with power of attorney?"

The audit goes on to look at whether certain information was documented and whether a required certified letter was sent and returned, Gallagher says. "The audit is done once a week by the lead case management assistant."

If the discharge planner ends up having to find the answers later in the process, Gallagher notes, "that is time that is not spent discharging people."

In November 2007, she says, the hospital added another IM review — looking at certain "electronic deficiencies" from the medical record standpoint.

"Before release, we tally up the deficiencies and see who is responsible for them," Gallagher explains. "Every day, but especially on Monday, there is a list [printed] of those patients who didn't have an [initial] Important Message in their charts or who didn't have a discharge Important Message."

The latter deficiency means that the patient got away without receiving the second notice, she says.

"We use the deficiencies [audit] to verify that the process is strong," Gallagher notes. "There are steps in place to catch these problems before the week is out," she adds. "Not more than a couple of days pass before we get notice from medical records [staff] that we missed somebody.

"Once we investigate, we often realize it is a process problem," Gallagher says. "Maybe the [IM form] was scanned into the electronic record but not put in the paper record, or it was sent up [to the nursing unit] in a tube and a nurse set it aside without putting it in the record. That is an education problem."

It is the policy at Stevens Hospital to contact patients who do not receive the IM to make sure they know they still have 30 days after discharge to appeal, she points out. "We get thanked pretty often by patients for being concerned about letting them know they have a right to appeal."

That practice remains in place, she adds, despite a request from the facility's QIO that the letters not be sent after discharge. "We don't send out many, but we want to make sure they have the 30 days."

There has never been a call from a patient regarding a possible appeal as a result of the letters, she says, probably because of the way the hospital presents the Important Message.

At some facilities the notices "are just handed" to patients, Gallagher notes, "and in those cases the QIO may get calls. Our presentation is more thorough. We say, 'If there are any questions, call us, and we'll send someone up to talk to you."

Although the hospital's after-discharge letters have not prompted inquiries about appeals, she adds, an unexpected result has been that patients have called to give feedback.

"They use the fact that our phone number is on [the letter] to say, 'I'm happy to sign this, and I just wanted to let you know I had a great stay in the hospital' or 'the discharge planner made

arrangements for all these things.'"

(Editor's note: ***Mary Bea Gallagher*** *can be reached at MaryBea.Gallagher@acs-hcs.com.)* ■

Director creates script for use in bed control

Aim is to avoid 'negative connotation'

At California Hospital Medical Center in Los Angeles "we never want [staff] to say, 'We do not have any beds,'" says **Elizabeth Oliver,** director for access care for the facility, which is part of Catholic Healthcare West (CHW).

While there are occasions when a bed is not immediately available, Oliver adds, the intent is to avoid any "negative connotation" or suggestion to the physician "that we don't want to take your patient."

"We wanted to say it in a different manner — something about [having] an opportunity to help them later — with a little scripting," she says. "I have scripts for patient assistance and collections and wanted to model those, to come up with something in the same format."

Oliver's plan was to give the bed management scripts to the hospital's preadmission/bed control nurse and to registration staff, who get calls for direct admits through the emergency department.

A little research and several phone calls to colleagues at other facilities found no evidence of scripts being used by bed management staff, Oliver adds, so she decided to write her own,

Script for Centralized Bed Coordinator

Note: All bed requests, transfers and admits must go through extension **** or (213) 742-****

I. Bed Request

CBC RN: "Good Morning/Afternoon/Evening. This is _____ in Bed Control. How may I help you? I will need for you to provide me with some information before I process your request. Can you please tell me your name, call back phone number and where you are calling from? In addition I will need the following information to process your request. *Patient demographic information, insurance information, diagnosis, any special handling or patient wishes. (A fax is requested to obtain a face sheet, insurance verification / authorization, Physician Orders and/or History & Physical [H&P].)*

Note:
- Acute to Acute transfers *always* require administrative approval.
- Assess medical criteria through InterQual (admission criteria)
  - o If patient *does not meet* admission criteria, follow-up needs to take place with the admitting physician to inform him/her.
  - o If patient meets criteria, proceed to insurance verification
- Always obtain verification of insurance through access care staff.

II. Bed Availability

Scenario 1 – Bed Available

CBC RN: Thank you for providing the information. We do have a bed available. Please have your patient check-in with admitting and we will get the patient registered and provide him or her with additional instruction. Thank you for your patience. Can I assist you with anything else?

Scenario 2 – No Room Available
(Do not ever make the statement we do not have any beds)

CBC RN: Thank you for providing the information. We are currently assessing our bed availability and I will call you back in ___ minutes. If you feel your patient needs emergent care, he or she can be sent to the ED. We really do apologize for the inconvenience. Is there anything else I can assist you with today?

which she is still in the process of tweaking. **(See draft bed management scripts, pg. 32.)**

"It was interesting to find that no one I called [at other facilities] does any scripting [for bed management]," she notes. "Some had ideas and word-of-mouth [suggestions], but nothing put together and written down."

Several of the people she spoke to at other hospitals asked her to pass along any scripting that she might create, Oliver says.

Her scripts address three different scenarios: In addition to the one used when no beds are available, there is a script giving language to use when a bed is available and another for the proper handling of an initial request for a bed.

The bed request script, she notes, asks for specific information from the caller, including patient demographics, insurance data, and other required documents.

Criteria sought for each unit

One of the other things her department is doing to streamline bed management, Oliver notes, is asking each nursing unit to provide its own criteria for admission. That allows the admitting nurse to look at, for example, the specific guidelines for admission of a medical-surgical patient in addition to InterQual criteria.

There are challenges, she adds, in regard to making sure that proper guidelines are followed in the admission of patients coming from outside the hospital and from the ED.

These guidelines would come into play, Oliver says, "if a physician in the area decides to admit a patient and wants to admit the person to the intensive care unit when he would be fine in med-surg."

*(Editor's note: **Elizabeth Oliver** can be reached at Elizabeth.Oliver@CHW.edu. Look for more information on the bed management process at California Hospital Medical Center in the next issue of* Hospital Access Management.*)* ■

Incident highlights lack of HIPAA understanding

CM denied police access to victim

A 2007 lawsuit involving an incident at a Louisiana hospital illustrates the lack of understanding among providers regarding the provisions and applications of the HIPAA privacy rule, notes **Elizabeth H. Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

The suit — filed March 30, 2007, by a case manager at Lafayette (LA) General Medical Center — related to a series of events that began on April 9, 2005, when a female victim of domestic violence came to the hospital's emergency department (ED) with injuries to her head, face, and forearm, Hogue says.

A nurse on duty called 911 to report the incident of domestic violence, she adds, and when an officer from the Lafayette police department arrived to investigate, he was told by a nurse that a woman had reported to the hospital with injuries she said were caused by her husband.

When the police officer tried to speak with the victim, according to reports, a hospital case manager named Elizabeth Maier refused to allow him to talk to the woman and repeatedly threatened to sue if the officer continued in his efforts to do so.

Maier based her actions on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contending that the hospital could not provide further information or access to the patient in the hospital due to legal prohibitions she believed were imposed by HIPAA.

When the police officer's superior arrived and explained to Maier that a Louisiana statute required an investigation of all incidents of domestic violence and that hospital personnel cannot deny police access to crime victims, Hogue recounts, the case manager continued to block access to the victim and threatened a lawsuit.

The two police officials then spoke to an attorney for the hospital and based on that conversation, understood that Maier would contact them when the patient was discharged, according to reports. Instead, the woman was discharged into the care of her husband, the alleged assailant, and Maier did not contact the police, Hogue says.

Police contended that Maier's actions obstructed and delayed their investigation of the domestic violence incident, and a warrant was issued for her arrest on the charge of obstruction of justice, she adds.

Maier was arrested and taken to the Lafayette Parish Prison in May 2005, Hogue says, but the prosecutor ultimately decided not to pursue the charges against her. Almost two years later, Maier filed suit against the police department, alleging violations of her civil rights (*Elizabeth Maier v. Morgan Green et al*; Civil Action No. 06-715, March

30, 2007).

Maier claimed the police officers should have known her actions were justified by HIPAA regulations, Hogue says, but the court stated that HIPAA does not bar police officers from obtaining information related to crimes directly from patients, nor does it prohibit health care personnel from allowing police officers access to patients who are victims of crimes.

The court further said that during her deposition, Maier could not identify any HIPAA provision that would prohibit police officers from asking patients who are victims of crimes to identify perpetrators. Instead, Hogue says, Maier asserted that the nurse who called police to report the domestic abuse violated HIPAA and the victim's confidentiality.

While noting that the exact issue presented in the case is not addressed in HIPAA regulations, the court went on to point out information provided by the U.S. Department of Health and Human Services (HHS) in "HHS Questions and Answers, FAQs on Privacy of Health Information/HIPAA Disclosures in Emergency Situations:"

"Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public consistent with applicable law and the provider's standards of ethical conduct."

Based on this provision, and considering the seriousness of domestic violence offenses in general, the substantial injuries the victim suffered, allegedly at the hand of her husband, and the fact that she was released from the hospital to the care of her husband, the court found, the HIPAA regulations did not prohibit providing access as requested by police.

The lawsuit filed by Maier was dismissed, Hogue notes, after the court concluded that her actions were based on an obvious "misconstruction" of the provisions of HIPAA, and that the police had probable cause to arrest her for obstruction of justice.

The implications of the failure to understand the HIPAA provision demonstrated by this case are potentially serious for both patients and providers, Hogue says. "Practitioners should review the privacy rule along with applicable statutes in the states in which they practice to avoid serious consequences."

(Editor's note: ***Elizabeth Hogue*** *can be reached at ElizabethHogue@ElizabethHogue.net.)* ■

Security at U.S. hospitals called 'growing concern'

Prepare response, lawyer advises

A recent security-related incident at a U.S. hospital is of "significant concern" and should serve as a wake-up call to health care leaders, suggests **Stephen Frew,** JD, a web site publisher (www.medlaw.com) and risk management specialist.

What he learned from individuals at a hospital security consulting firm with which he works, Frew says, is that a security officer approached two men of "apparent Middle Eastern descent" who were videotaping inside a hospital that he does not name.

"Security [officers] had them shut off the video recorder and asked for identification," he recounts. "They responded that they did not have any identification and they then proceeded to go outside and get in their vehicle and leave the property."

The vehicle was a rental car, Frew notes, which he says strongly suggests that the individuals lied about their lack of ID.

Security cameras obtained footage of the men and it was furnished to police, he adds. The report of the incident does not indicate whether any attempt was made to detain the individuals or whether they offered any explanation of their activities, Frew notes. "The context of the report suggests that they did not."

It is also not clear from the report if the person who approached the two men was a private security officer or a police officer on duty as a private or public security officer, he says.

Frew suggests a range of possibilities that might explain the incident. Tongue firmly in cheek, he says the two could be "tourists interested in hospital architecture who entered the country without passports or ID, but because of their obvious good character were allowed into the country and were rented a car anyways."

Another scenario, Frew says, is that the men were employees of a plaintiff's lawyer who is suing or will be suing the hospital and that they fled to cover their true status.

As a third option, he adds, "is there a remote chance that these individuals were involved in 'casing' the facility for illegal activities of some nature, ranging from theft to kidnapping to terrorism?"

Frew points out that he has warned periodically of the tempting target hospitals could be to terrorists.

"There is no one right answer to how hospitals should plan for and react to such situations," he says. What's important, Frew adds, is that health care facilities consider such threats and have a response prepared.

"This is not the first reported incident of individuals without identification filming or posing as inspectors," he notes. "Hospital security is a growing concern and should be a priority in routine and emergency operations planning." ■

Longer ED waits highlighted in study

Emergency department patients waited an average of 30 minutes to see a physician in 2004, eight minutes longer than in 1997, according to a study of U.S. ED visits published on-line recently by Health Affairs.

Heart attack patients waited an average of 20 minutes to see an ED physician, 12 minutes longer than in 1997.

The estimates are based on an analysis of 90,000 visits to the ED by adults from 1997-2004, a period in which U.S. ED use increased by 16.8 million visits annually.

"Even as the demand for emergency care has increased, many hospitals have closed — along with their EDs — due to pressure to reduce capacity," said Caroline Steinberg, vice president for trends analysis for the American Hospital Association.

While today 99% of acute care hospitals provide emergency services, the same percentage as in 1990, there are fewer of them, Steinberg pointed out, leading to increased patient loads. In addition, she said, many of the new hospitals that are opening — physician-owned, limited-service hospitals — are choosing not to provide ED services. ▼

'50-mile rule' does not cover where patients can go

A fee schedule change affecting payment for ground ambulance charges under Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low-density population areas, and provides a 25% bonus on the mileage rate for ground transports of 51 miles or greater. The bonus on the mileage rate for ground transports of 51 miles or more has been misinterpreted by some providers to mean that a Medicare patient cannot be placed in a bed more than 51 miles away — an interpretation that is not correct.

During the five-year period covered by the schedule change (July 1, 2004-Dec. 31, 2009), fees for urban and rural transports are increased, and through the end of 2008, a 25% increase is applied to the base mileage rate for each mile of transport that exceeds 50 miles when the Medicare beneficiary is on board the ambulance.

Though the fee changes affect reimbursement for ambulance services, the "50-mile rule" does not restrict Medicare patients from being placed in facilities 50 miles away from their starting point. ▼

Hospitals, health systems on 'Best Companies' list

The 2008 *Fortune* magazine list of "100 Best Companies to Work For" includes 11 hospitals and health systems, including Methodist Hospital System in Houston, which placed 10th.

That organization was followed by OhioHealth in Columbus, OH (18th); Children's Healthcare of Atlanta (45th); Griffin Hospital in Derby, CT (49th); Scripps Health in San Diego (56th); Mayo Clinic in Rochester, MN (59th); King's Daughters Medical Center in Ashland, KY (63rd); Southern

Ohio Medical Center in Portsmouth, OH (75th); Arkansas Children's Hospital in Little Rock, AR (76th); Lehigh Valley Hospital & Health Network in Allentown, PA (85th), and Baptist Health South Florida in Coral Gables, FL (94th).

Selection is based on employees' attitudes and the companies' pay and benefits, hiring practices, internal communications, training, and recognition and diversity efforts.

Applications for 2009 are due March 31, 2008, and are available on-line. ▼

CAHs can participate in OP quality reporting

The Centers for Medicare & Medicaid Services (CMS) has granted a request from the American Hospital Association (AHA) to allow critical access hospitals to submit and publicly report outpatient quality data along with other hospitals.

Hospitals participating in Medicare's outpatient prospective payment system (OPPS) are required to submit data on seven outpatient quality measures to receive a full payment update in fiscal year 2008.

The program contractor announced in December 2007 that critical access hospitals, which do not participate in the OPPS because they receive cost-based reimbursement, would not be allowed to submit the outpatient measures.

AHA had urged CMS to let the critical access hospitals participate in the quality reporting, citing their commitment to public transparency and quality improvement. ■

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