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Employee retention, need for space drive telecommuting focus at CHS

Candidates ranked on 'where they stand in productivity'

Employee retention, an ongoing need for space, and the visionary thinking of a senior vice president are among the driving factors of an ongoing focus on telecommuting at Carolinas HealthCare System (CHS) in Charlotte, NC, says **Chris Johnson,** FHFMA, vice president for patient financial services.

Fifty employees within the CHS revenue cycle areas at its five Charlotte-based facilities are working from home, Johnson adds, including 16 in pre-service, one in financial counseling, and 23 in patient accounting. Another 10 telecommuters make up the reference lab registration staff, he notes. **(See related article, pg. 52.)**

"The whole telecommuting concept began about five years ago," he says. "It started slowly. The first year we had three people, and we did it as a trial. Space is always at a premium and there is documentation that those who work at home are more content."

Providing additional impetus, Johnson notes, was a senior vice president "who is always saying, 'Why can't we do this?'" regarding a variety of cutting-edge ideas.

"[The senior VP] even brought up the issue of the pending pandemic — what to do when everyone has the flu," he adds. "When that does hit, how can we keep people working?"

Weather conditions also were factored in, including the employee absentee rate on a "snow day" in an area not accustomed to severe weather, Johnson says. "If we had people at home, they could continue working and we could get our jobs done."

The results have indeed been positive — with a 5% or greater increase in productivity, he says. Telecommuters don't have as many interruptions as their on-site counterparts, Johnson points out, and are not tied to break times or distracted by people coming by to chit-chat or by meetings or unplanned events.

On the other hand, notes **Katie Davis,** CAM, director of pre-service, not everyone is a good candidate for telecommuting.

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"We really rank people on where they stand in their productivity," she says. "We feel we have to be very fair about the process. Are they meeting their key performance indicators? For insurance verification, for example, 'carryovers' is one of their measures. They can't have over a 2% carryover rate. If they do, they understand that prohibits them from going home at this point."

Working at home is a privilege, Davis says, whether the employee in question is a "top A" or a "B" performer.

When CHS started the process, Johnson notes, "we would allow only our high-performing employees to go home. Their most recent evaluation had to be 'exceeds expectations.' Then we realized all of our best people were at home. That created some dissatisfaction with managers."

With only the average and below-average employees left at the facilities, he adds, "there were no more 'go-to' people on-site."

Once CHS leadership determined that the telecommuting initiative was workable and would be a long-term commitment, Johnson says, the decision was made to allow average employees to participate.

"Our conclusion," he adds, "was that if you're a good, solid, dependable employee and you want to be a telecommuter, what is the downside to us? We haven't lost anything. That has proven to be true."

Employees who have received disciplinary actions still are not allowed to work at home, Johnson says, but a "'meets expectations' evaluation is sufficient to qualify."

There are some employees — those who like social interaction and the office environment — who don't want to telecommute, he says. "It's not for everybody. In our experience so far, there was only one person who tried it and said, 'This is not for me,' and one about whom we decided, 'This is not for you.'"

In the latter case, Johnson says, the person needed more supervisory oversight.

If a telecommuter's productivity level drops or there is any significant disciplinary action, he adds, "we have a conversation about why."

Disciplinary action might be required, for example, if there is a bad interaction with a patient or if calls are made before or after the allowed times, Davis says, noting that all phone calls are recorded.

Additionally, she says, "our policy is plain about the fact that you must have working space at home. If there are small children or elderly parents who need care, they must be taken care of by somebody else [during work hours]. A screaming child in the background is not a customer-friendly situation."

CHS has established a number of guidelines for its telecommuters, who must abide by all the requirements — HIPAA-related and otherwise — that on-site workers follow, Davis points out. **(See list of guidelines, pg. 51.)**

These requirements, she adds, relate to such concerns as, "If the employee gets up and leaves the desk, is the computer locked, with no patient data up on the screen? Is paperwork turned over

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CHS telecommuters must meet guidelines

In addition to employment qualifications for registrar/patient account representative, staff assigned to telecommuting positions at Carolinas HealthCare System (CHS) in Charlotte, NC, must meet the following qualifications before working from home:

1. Be employed by CHS financial services (registration, financial counseling, or patient accounting) for at least 12 months.
2. Receive "meets expectations" or higher on the most recent annual evaluation.
3. Have received no verbal counseling and/or disciplinary action in the previous 12 months.
4. Be approved by the assistant vice president.
5. Commit to a minimum of one year in the telecommuting program.
6. Submit to a 90-day "manager's discretion" probationary period.

Before working from home, the employee must provide the following.

1. A signed copy of the Employee Telecommuting Agreement Form.
2. A permanent workstation consisting of a desk or table at least 24" X 48".
   a. The workstation is to be located in an area that will provide privacy (for example, not a kitchen table) such as a guest room or home office.
   b. The desk must be in a "ready to install" state before technicians arrive.
   c. There must be an ergonomic chair positioned at the workstation.
   d. No entertainment center/armoire-style desks will be allowed as they tend to be too small for the required equipment and often require moving to complete the install.
3. A properly grounded 3-prong electrical outlet for the connection of CHS equipment.
4. Adequate lighting.

The employee is responsible for the following when working from home.

1. Cost of electrical service to the employee's home. Loss of electrical service due to disconnection for non-payment is grounds for immediate reassignment of employee's work location to a CHS location specified by management.
2. Disposal of shredded documents containing patient information.
3. Total privacy of all patient information and communications:
   • All patient information documents and schedules are to be shredded.
   • Patient documents needed for work must be stored in a locked container.
   • Headphones must be used when talking on the phone.
   • There must be strict adherence to CHS confidentiality and acceptable use policies.
   • There must be strict adherence to all CHS HIPAA policies.
4. Ergonomically correct workspace free of safety hazards.
5. Notifying manager of any equipment problems or malfunctions.
   • Notifying CHS information systems support of any hardware, software or connectivity problems related to the operation of the PC, or any problems related to telephone operation. (Employee is responsible for transporting hardware [PC, monitor, printer, etc.] to CHS for repair.)
6. Being present at all times while CHS technicians are on-site at the home.
7. Wearing business casual or normal "working" attire at all times when CHS technicians are at the home.
8. Cost of relocating telephone and/or cable service connection within two years of initial installation by CHS or relocation cost paid by CHS.
9. Tax implications and reporting requirements for home office as statutory law may require for IRS and/or state department of revenue.
10. Transportation costs to attend meetings, training, etc.

CHS is responsible for the following.

1. Cost of initial phone and/or cable installation in employee's home.
2. Cost of relocation for phone and/or cable once every two years.
3. Cost of cable and/or phone monthly service and associated charges.
4. Providing PC, software, connectivity, and IS support.
5. Office supplies (paper, printer cartridges, etc.) normally used for work. ■

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so no one can see anything?"

Unannounced home visits are made throughout the year, Davis says, including HIPAA compliance checks.

One of the most clear-cut measures of the program's success, notes Johnson, is that none of the telecommuters have left their positions.

"One of the questions on the annual employee survey that we do for [home-based employees] is, 'Would you continue to telecommute, even if you were offered a [non-telecommuting] job that paid 10% to 15% higher than your current pay?'" he says. "They said yes."

[Editor's note: Chris Johnson can be reached at chris.johnson@carolinashealthcare.org. Katie Davis can be reached at katie.davis@carolinashealthcare.org.] ■

Lab's scanning process enables telecommuting

Entire department home-based

At Carolinas HealthCare System in Charlotte, NC, where telecommuting is a growing trend, one department in the revenue cycle arena is made up entirely of employees who work from home, says **Chris Johnson,** FHFMA, vice president for patient financial services.

The 10 employees who perform registrations for the reference laboratory began telecommuting about a year ago, Johnson adds, in the wake of some changes in the way the area functions.

"Until a year and a half ago, the reference lab process was entirely paper-based," he notes. Some 1,250 lab requisitions come in each day, in large groups, from physician offices, Johnson says, "and historically, one to two pieces of paper were sent with each account."

In order to process a specimen in a timely manner, he explains, the lab creates a "pre-account" — containing four pieces of basic information — on each to get an account number, and access employees finish the registration at a later date.

That process changed when CHS contracted with a scanning company, Johnson adds. "The lab still creates the pre-account, but all of the documents that come in with it are scanned, so [access staff] can work from scanned documents instead of being given folders and folders of paper."

The access employees then enter the demographic and insurance information necessary to bill each account, he says.

The original intent of scanning was to reduce paper — not to allow people to telecommute — but once that piece was in place, Johnson notes, "reference staff started asking why they couldn't work from home."

That dovetailed nicely, he adds, with the fact that "our facilities really needed the space" that would be freed up.

The arrangement has worked out well, Johnson says. "Reference lab staff are very content with the opportunity to work from home, which allows them to be more flexible."

The very specific guidelines that dictate the work hours of other telecommuters are not required for these employees, who are working from documents 90% of the time, he notes. "The exception is when they have to call a physician or patient to get more information and then they don't call before 8:30 a.m. or after 8 p.m."

Another exception, Johnson adds, is the period from midnight to 6 a.m., when the computer system is processing. ■

Saint Barnabas 'Link' fills needs systemwide

Call center responds 'upon request'

When a need is expressed within Saint Barnabas Health System, based in Livingston, NJ, there's a pretty good chance its off-site call center, known informally as "the Link," will be able to help in some way, says **Belynda Delgado,** MSN, BSN, RN, director of Saint Barnabas Health Care Link.

The non-clinical call center provides solutions "upon request" for various entities within the six-hospital health system, says Delgado, whose first piece of advice to call center managers is "never say no to any project. It's an investment for the facility."

Four years ago, Health Care Link took over call center functions that previously had been outsourced, she adds, and it shares space with a pre-existing behavioral health call center.

Among other things, staff at the Link preregister patients for blood tests, mammograms, echocardiograms, diabetes education classes, and physical therapy, and they also arrange physician

consultations, Delgado says. They also make follow-up calls to emergency department patients discharged the previous day, do survey callbacks, and send out "a lot of mailings," she adds.

What Delgado stresses to her staff, she explains, is the need to educate the public. If a patient calls for a physician referral, for example, employees are directed to "let them know that's not all you do. If they don't know what we have, they won't call us back."

Health Care Link began with 2.5 full-time equivalents (FTEs) and has quickly grown to include eight representatives, soon to be 10, Delgado notes. "I just got approval to add two positions."

The Link began arranging physician consultations in the summer of 2007, she says, acting as a sort of concierge for physicians seeking a consult for a patient in one of the Saint Barnabas facilities.

"The physician calls us and requests that the patient be seen by a consulting physician," Delgado adds. "We call the consult and tell [him or her] about the patient and why [he or she] needs to be seen. We reach out to the offices and make the appointment for them, and the consulting physician goes to the hospital and sees the patient."

As of about mid-April 2008, the process will be done electronically, she says, with the initiating physician making the request, "just like entering an order in the hospital computer, which is in sync with our software."

Call center staff began arranging the consults — which she calls a "great physician pleaser" — for Newark Beth Israel Medical Center, the health system's cardiac teaching hospital. "We started with the adult medicine physicians, and in a month will include the pediatricians as well," Delgado adds.

Once that piece is in place, she says, the call center will extend its service to arranging follow-up appointments with the physicians.

The calls made by call center staff to ED patients discharged the previous day are designed to support patient care and enhance customer service, Delgado notes, but also provide a way to introduce patients to Saint Barnabas physicians.

"We ask [questions like], 'How's it going? Are you feeling OK? Do you need a doctor?'"

Staff can segue to physician referral, she says, with the ability to search for physicians using criteria such as insurance type, education, gender, language, distance from home, and years in practice.

In another successful initiative, Delgado recounts, the Health Care Link turned around the process whereby patients are registered for blood work at Kimball Medical Center, a Saint Barnabas hospital in Lakewood, NJ.

The first-come, first-served process in place in the department was resulting in bottlenecks, she says, which was becoming a customer service issue as elderly patients and people who had been fasting waited a long time for their blood tests.

Her suggestion, Delgado says, was, "what if those patients called the Link, read their [physician orders] to us, and we preregistered them over the phone?"

Now, instead of coming in and waiting their turn, patients have the option of preregistering through the call center, she adds. "We schedule the appointment and ask what type of blood test they are having and which physician is ordering the test."

Education, scripts provided

Call center staff, meanwhile, have been provided with information regarding blood work, Delgado says, including a script to help them answer any questions patients might have. As with other areas, she notes, "if it gets too clinical, they refer them to the facility."

Staff also have been certified for preregistration, Delgado says, receiving the CPAR, or certified patient access representative, designation used in the Saint Barnabas system.

Patients are informed of the preregistration option through flyers and other routes, she says, but perhaps the most effective advertisement is seeing a patient who just walked in go ahead of them for service.

Appointment times assigned by Health Care Link staff mimic the hospital schedule, with times set for 9 a.m., 9:15, and so on, Delgado explains, and preregistered patients are instructed to go to the front desk and tell the person there that they have an appointment.

Hospital staff refer to an appointment list that has been forwarded to them by Delgado and pull the chart for that patient, who is asked for the physician order and a couple of signatures, she says. "Five minutes and they're out."

Delgado stays in touch with the physician liaisons for the six Saint Barnabas hospitals, dis-

cussing such issues as the high demand for certain specialists, she says. "They are my conduit to the community."

Using data gleaned from Health Care Link calls, Delgado notes, she also can communicate the need for various educational services. "I also deal with the public relations director [regarding] the information I have internally that goes out to the public and vice versa."

Because of Health Care Link's growing and continually updated database, she says, "we've become the mailing list" for brochures and other health system mailings.

"We have repeat callers who know us now," Delgado adds, "so we need to let them know what we have, and that if it's not available in one facility, we can refer them to a sister facility."

To ensure that Health Care Link continues to be a valuable resource, Delgado takes a proactive approach, she explains, checking on ongoing projects and studying processes "so I can figure out how the Link can help ease a process or help customer service. I've learned to deal with administrators and managers and educate them on what we do and how we can help them."

Crucial to that effort are one-on-one teaching sessions with staff, Delgado says, "to make sure they're documenting the same way." In-services conducted by departmental representatives on, for example, digital mammography also are important, she adds.

"You can only cross-market what you know," Delgado points out. "If you just blindly transfer a caller, that's not a good thing. The more knowledge [the call center employee] has, the better. If the question gets too technical, we refer the caller to the department."

Staff retention

With an eye on staff retention, she says, call center employees are rewarded for productivity and good outcomes.

"It's important for us, when we give out physician referrals, to follow up in a week or so and see if the caller did make that appointment," Delgado adds. "It's your return on investment. We document that, and on a monthly basis, track the number that each counselor has made."

Statistics are compiled and call center employees are recorded accordingly, both individually and as a group, with gift certificates or perhaps being treated to lunch, she says.

Employees also are recognized on an annual basis, notes Delgado, who has developed her own criteria for performance measurement.

"It's a combination of customer service [observed through silent monitoring], physician referrals, attendance, being a team player, professionalism, and number of transactions completed," she says. "I also take into consideration compliments that [staff] received."

[Editor's note: Belynda Delgado can be reached at bdelgado@sbhcs.com.] ■

Registration time shrinking with use of check-in kiosks

Satisfaction levels monitored closely

Patients at the Medical Center of Central Georgia (MCCG) in Macon "are responding very well" to the use of check-in kiosks, which have led to dramatic reductions in the amount of time they spend being registered and waiting for service, says **Jane Gray,** CPA, FACHE, FABC, assistant vice president for patient business services.

In place at MCCG's Georgia Heart Center since April 2007, the registration kiosks were expanded to the facility's diagnostic center in July 2007, Gray adds.

The most recent statistics from the heart center show that the average time a patient spent waiting to speak to a greeter went from a minute and 33 seconds to about 30 seconds while the average wait to be registered went from eight minutes and 45 seconds to "no wait time," she says, "because the greeter [immediately] directs the person to a kiosk or hands them [an electronic] tablet to work with."

Previously, registration processing time was 11 minutes and 45 seconds, but is now five minutes and 29 seconds, Gray notes. "Overall, we're cutting about 15 minutes from registration."

The diagnostic center environment is different in that patient volumes fluctuate between 30 and 60 a day, she says. "We can't staff for 60 all the time, so on the heavy days we would get bottlenecks."

The advent of the registration kiosks has trimmed about 20 minutes off the entire registration process there, Gray adds, "and we are able to schedule much more heavily."

To gauge acceptance levels for the new technology, patients at both sites are presented with

satisfaction surveys once check-in is complete, she says, and scores are monitored closely. Responses have been positive overall, Gray says, with most patients finding the kiosks easy to use.

Any negative responses are acted on immediately, she notes.

Lessons learned during the kiosk implementation process — which Gray and patient access director Kim Whitley will discuss in a presentation at the Healthcare Financial Management Association's (HFMA) Annual National Institute in June — include starting with an area that "buys into" the technology.

They also offer the following advice for providers considering a similar initiative.

- Select a strong project leader who understands the registration process.
- Engage registration staff as part of the process.
- Promote self-service to patients before roll-out.
- Enable integration between self-service application and existing back-end systems to minimize duplicate data entry.
- Kiosks cannot be optional, although the rare patient will require full service via the kiosk.
- Be sensitive to the surprise factor in asking patients for a large payment without prior notice.
- Learn from the experience of early adopters — internally and externally.
- Expect limited resistance: You can't please 100% of the people 100% of the time with any method.

"What we're also talking about in our presentation is how self-service is really becoming commonplace in all industries," Gray says. "Depending on what generational group you're looking at to build loyalty, consider that the younger generation expects a technology alternative. It helps to build loyalty and the image of being state of the art that goes along with it."

At MCCG, people of all ages are using the kiosks, she notes, and many view kiosks as a service enhancement. "Patients are familiar with self check-out from local supermarkets and retail stores in the Macon area."

Research indicates a comfort level with technology that is not limited to members of Generation X (born 1965-1976) and Generation Y (born 1977-1998), Gray says.

"The Baby Boomers [born 1946-1964] are not that far behind Generation Y in daily mobile Internet access," she points out, "and the senior population also is becoming comfortable with computers and the Internet."

[Editor's note: More information on MCCG's implementation of the MediKiosk, a product of Maitland, FL-based Galvanon, is available in the July 2007 issue of ***Hospital Access Management****. Jane Gray can be reached at gray.jane@mccg.org.]* ■

Data tracking, standardized tools aid in psychiatric care

Provider cooperation essential, manager says

Health care leaders at Shoal Creek Hospital in Austin, TX, and in the city as a whole are taking steps aimed to make it easier for psychiatric patients to get access to care.

Challenges they face include a lack of readily available psychiatric expertise and communication barriers between caregivers, says **Mark Catalano,** LCSW, Seton Shoal Creek Hospital's manager of admissions.

Initiatives designed to streamline the process include a mobile assessment team, telecommuting, standardization of tools and data tracking, and enhanced cooperation and communication between psychiatric hospitals and the emergency department clinicians who send them patients, he adds.

A major focus at Seton, Catalano says, is on "trying to create windows so that ED physicians and social workers know our capacity, what kind of patient is best for us, and which patients go on which unit." It's crucial not only to let them know what's available, he points out, but to realize that each facility has its own way of describing patients.

Seton Shoal Creek uses a standardized risk assessment tool on every patient, including those in inpatient units, Catalano notes. "What we need from the ED [caregiver] is how high the risk is for that patient."

The number derived from the assessment determines whether and where the patient will be placed at the facility, he adds, but often the ED clinician is "not speaking the same language" as staff at the psychiatric facility during the assessment process.

In many cases, Catalano says, the patient in question has been to Seton Shoal Creek before. "We may have seen the patient 10 times, but he or she is new to ED staff and they describe the

patient in a way that conflicts with our experience."

A behavioral health patient who presents at the ED "may be at the baseline for him or her," he adds, "but the ED [care provider] thinks the person is out of control." With accurate communication, Catalano says, "we may be able to say, 'Oh, that patient is just coming in to get a meal,' and give them suggestions on how to handle the person."

With such issues in mind, Austin's behavioral health leadership is working to standardize the assessment process across the city, Catalano says, "and see if we can agree on a core set of assessment tools, such as CIWA [Clinical Institute Withdrawal Assessment], CINA [Clinical Institute Narcotics Assessment] — neither of which is used by any of the EDs — and a suicide or homicide/aggression assessment."

The implementation of such tools, he adds, will require education for ED nurses and social workers.

A pilot program started at Seton in July 2007, Catalano notes, focused on training social workers throughout the hospital network.

"We brought in all of our on-call social workers for the network — those who work all night — and educated them on our internal assessment forms so they could do our assessment for us," Catalano says.

When presented with data "on forms we recognized and used, with scores we would use internally," he adds, Seton personnel "know we can trust that [information]."

The payoff carries through to the utilization review piece of the process, Catalano notes, "when from the beginning we get good documentation."

Also under way, he says, is development of a software-based database that would allow "all the players — the ED, the emergency medical services and the behavioral health hospitals — to share information," he says.

That information would be available, for example, when a patient presents to the ED or is en route to the hospital with an overdose, Catalano adds. With standardized data in one system accessible to all, he says, caregivers can check to see if and where appropriate beds are available for the patient.

With initial responders using the standardized screening tool, Catalano says, "Austin's two private psychiatric hospitals could quickly respond to an alert on a patient needing care with, for example, 'We've got a Level 12 bed on this unit, and it looks appropriate.'

"What EDs want from us is for us to pull patients rather than them having to push them," he points out, "and the more we can trust the form and the language, the more we can do that."

View EDs as customers

In the past, behavioral health providers tended to have an adversarial attitude toward the various EDs in town, Catalano notes. "We realized that we were looking at EDs as the enemy, feeling they were trying to dump patients or not give us all the information and [cases would be] different from what was presented on the phone."

The reality, however, is that the EDs "are our customers — the front line that finds patients for us," he says. "We've tried to [shift] our thinking and say, 'What do we need to put in their hands so they are better able to deal with the patient and can become our best sales force?'"

Seton Shoal Creek was on track to develop a mobile assessment team for behavioral health patients, Catalano notes, but it now looks as though the city of Austin — with matching in-kind contributions from the hospital networks — will take leadership of that project.

The idea, he says, is for caregivers to load information into a city-wide system while observing a patient onsite.

"We're looking at putting together teams in which a social worker and nurse would go out and look at the patient, with one psychiatrist assigned to oversee a certain number [of teams]," Catalano explains. "The psychiatrist would be available to evaluate the individual in person if necessary or could use telecommunication to consult on the case."

Personnel for the mobile assessment team would be hired for the city under the auspices of the state Mental Health Mental Retardation department, he adds. The operation would be tied to the state psychiatric emergency services, Catalano says, "which are the 24-7 gateway to the state [behavioral health] hospital or other services."

At Houston's Memorial Hermann Hospital, where Seton staff made a site visit, a mobile assessment model is in place, he notes. "A medical director is paid to be available and is on call if the nurse or social worker on the team goes out and needs the physician piece."

The psychiatrist participation is "more to help

smooth things out with the ED physician if the social worker is recommending something and the ED physician is not in agreement," Catalano says. "The trust factor is a barrier."

Houston is "a year or two ahead on the [telecommuting] curve," he adds. "It's another option for the mobile assessment team if they can't get to the facility across town in a timely fashion. Depending on the level of need, the social worker might do the initial assessment or the physician on call might do it."

In Austin, Catalano continues, there are plans to use mobile assessment in the same way. Returning to the example of a patient in the ED who has been there all night and into midmorning, he says, if such an individual could be interviewed via telemedicine by a psychiatrist or other behavioral health specialist familiar with his or her case, a lengthy stay and possible admission may be avoided.

"This is a way to reach out into the front line and add our level of expertise," Catalano says. "We see these kinds of patients day in and day out."

[Editor's note: Mark Catalano can be reached at mcatalano@seton.org.] ■

Call centers play vital role in ED psychiatric care

Quick deployment of clinicians possible

A behavioral health call center has an important role to play in the treatment of a psychiatric patient who presents at the ED, says **Sue Altman,** president of the Phoenix-based Call Center Consulting Network.

"The ED is really set up for medical patients and typically is already overcrowded," adds Altman, who offers strategic planning and positioning services for call centers. "Behavioral health issues are usually not dealt with very quickly in the ED. The last thing you need is somebody having a meltdown."

ED clinicians, of course, do a screening as quickly as possible to determine if there is a medical issue, she says. "If there is an overdose, obviously they would process that and, if necessary, admit the patient to a [nursing] floor."

However, a situation in which someone appears to be disoriented, with homicidal thoughts, auditory hallucinations or delusions, Altman says, "is usually not something an ED physician is comfortable assessing."

In such cases, she continues, ED staff would contact the call center, "which would get someone there to assess patients and get them on their way to the right destination for care, including [arranging for] some kind of transportation, often an ambulance."

That could mean mobilizing a social worker who is in a different part of the hospital, she says. "Case managers may be trained to do these quick assessments if need be."

If the facility is part of a system of hospitals and the necessary resources are not available at that location, Altman says, call center staff may call on one of the system's behavioral health professionals who may have to drive there quickly.

"They will do an assessment," she explains, "and typically call the call center back because it is arranging bed availability. Call center staff," Altman adds, "would know if the behavioral health facility or state hospital or psychiatric emergency service — which is like a big psychiatric ED — has a bed."

These psych EDs can hold a patient for 23 hours, but don't have inpatient facilities, she notes. "When patients present at the ED with bipolar [disease] or other conditions, in most cases, if they can be started on meds, within 23 hours — the length of time they can be held for observation — [staff] can have them under control and they can go home, with some follow-up."

One of the problems in the behavioral health arena, Altman says, is that people who need the services don't know how to navigate the system. "Psychiatric or behavioral health services are not typically organized to serve an entire city or organization."

In medical care, physician offices are the "feeder system" for hospitals, she points out, but there appears to be a big disconnect between the psychiatric hospital and private practice psychiatrists or therapists.

Even people who have health benefits may not have much coverage in this area, Altman notes, and "there is a big movement for therapists not to accept insurance at all."

"[A condition] that may have been nipped in the bud if the patient had talked to someone at the primary care level may get really out of control before a family member [intervenes]," she adds. "If these people can't afford care or don't have resources or fear the stigma, they may lose

their job and alienate from the family before it's obvious they need care badly."

The nation's uninsured population is another growing crisis, Altman says, which "hurts on both the medical and psychiatric side."

In two or three cities where Altman is working on call center strategies, she adds, private and governmental behavioral health providers are joining forces to look at solutions to the breakdown in services.

"What they recognize is they're all seeing the same patients, and end up just trading them," Altman points out. They may receive inpatient care, she says, "but once they return to their lives, if they can't get in to continue management with a psychiatrist, you're really just putting them right back in the same situation."

Efforts under way to centralize and track data, Altman says, are designed to answer questions such as, "Are [providers] seeing the same 100 patients or are there really 1,000 patients?"

"We know how many go through each of the [organizations] — they all have the counts — but until we look at the data level, we won't see that Jane Smith has visited all of us in the past month," she adds. "It could look like 1,000 people need services, but it could be the same 400 coming two or three times a month."

[Editor's note: Sue Altman can be reached at sue.altman@3cn.org.] ■

States may strengthen provider referral regulation

Attorney cites recent SC case

There are signs that states may become more aggressive in their regulation of provider referrals, suggests **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

Federal regulators have long been active in the oversight and monitoring of referral arrangements, she says, with the federal anti-kickback statute and the so-called Stark laws as the bases for these activities.

While many states have also enacted statutes and implemented regulations governing referrals, Hogue adds, a recent decision by the Supreme Court in South Carolina indicates they may be taking that focus to a new level of emphasis.

In *Sloan v. South Carolina Board of Physical Therapy Examiners,* No. 26209 (S.C. Sept. 25, 2006), the Supreme Court concluded that a state statute prohibits physical therapists from being employed by physicians who refer patients to them for therapy services, she notes, and also specifically recognized the right of the state's Board of Physical Therapy Examiners to enforce the statute against therapists who violate it.

South Carolina Code 40-45-110(A)(1), enacted in 1998, states that the Board of Physical Therapy Examiners may restrict, renew, suspend or revoke licenses of physical therapists when the board decides that therapists "request, receive, participate, or engage directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services or profits by means of a credit or other valuable consideration, including wages, with a person who referred a patient."

Before 2004, the board did not take any action to enforce the statute, Hogue says, but in that year the attorney general of South Carolina issued an opinion addressing the statute. "Specifically, the attorney general said that physical therapists cannot work for physician-employers who make referrals to them."

After the attorney general's opinion was issued, she adds, the board voted to endorse it, and then announced at an open meeting its intention to begin enforcing the statute. The board also announced that no enforcement action would be taken for 90 days, Hogue continues, so that physicians and therapists would have a chance to modify referral relationships that violated the statute.

Individual practitioners and state trade associations joined forces to sue the board to prevent it from enforcing the statute, she says, and the trial court decided in favor of the board. That decision was appealed to the South Carolina Supreme Court, Hogue adds, and the Supreme Court upheld the board's position despite a number of arguments raised against it.

The court, she says, generally expressed concern about over-utilization, stating in part, "It is no great stretch to conclude that [40-45-110(A)(1)] was passed for the same reasons which prompted enactment of the state Provider Self Referral Act."

Those reasons, the court goes on to state, were to protect consumers, as well as Medicare and Medicaid, "from actual and potential conflicts of interest, which are likely to lead to overuse of

medical services by physicians who, for their own financial gain, refer patients to entities in which the physicians hold a financial interest."

As a result of the court's decision, Hogue advises providers to take these actions:

• Review statutory and regulatory requirements, if any, in the state(s) in which they do business to make sure they are in compliance with these requirements.

• Closely monitor new developments in the state(s) in which they do business so that they are up to date on recent developments and can account for them as they structure referral arrangements.

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

New patient notice rule sparks EMTALA queries

Wait until after MSA, attorney says

A new requirement by the Centers for Medicare & Medicaid Services (CMS) affecting critical access hospitals and others that do not have physicians on duty 24-7 has prompted questions regarding EMTALA, says **Stephen Frew,** JD, a web site publisher (www.medlaw.com) and risk management specialist.

As of October 2007, CMS requires that these hospitals provide patients with written notice of that lack of coverage and an explanation of their plan to deal with emergencies when a physician is not on the premises.

The rule was primarily aimed at specialty hospitals that do not have medical staff on site 24-7 and that have come under criticism for transferring patients in the middle of the night to general hospitals if their conditions deteriorated, Frew explains.

"Recently, we received a question about whether EMTALA might be violated if a patient were advised that there was no physician on duty 24-7 and the patient chose to leave, resulting in a failure to provide a medical screening exam," he says.

His response to the inquiry, which he confirmed with a regional CMS office, is that "the appropriate time to provide the notice would be after completion of the medical screening examination, following stabilization, during the admission process," Frew adds.

Giving the notice prior to that, he says, might be considered a denial of services by the patient, resulting in an unintentional EMTALA violation.

"If the patient is intended for admission, but after receiving notification that a physician is not present 24-7, decides he or she wishes to go with a hospital that does have [round-the-clock] coverage, there are additional EMTALA implications," Frew says, which he explains below:

1. This would be a patient-initiated transfer, and it will be necessary for the hospital to complete the necessary transfer forms and arrange an appropriate transfer.

"Patient-initiated transfers, however, are not viewed as 'higher level of care' transfers under EMTALA acceptance rules, and receiving facilities are not [required] to accept," he says. "Additionally, insurance or Medicare may deny payment for ambulances because the transfer is not deemed medically necessary. If the receiving facility refuses acceptance, the hospital must continue to render care while attempts to find an accepting destination are pursued."

2. If the patient refuses ambulance transport, it will be necessary to obtain a written refusal of ambulance.

If the patient refuses to sign the refusal of ambulance form or attempts to leave on his own, Frew adds, the hospital must document all of the reasonable efforts made by staff to obtain the patient's signature.

3. These situations are prone to confusion and complaints, so attention to complete documentation is critical.

"Be sure to document that the notice precipitated the patient's request and that the notice was provided as required at the time of admission," he says. "Document all efforts to effect the requested transfer and any refusals." ■

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'Medical home' model getting more attention

Fewer shortfalls in care reported

Interest appears to be growing for the "medical home" model of care, which provides patients with a coordinated, comprehensive approach to primary care.

The Association of American Medical Colleges (AAMC) views the medical home model as promising and supports further research on how to best implement it, the association announced recently.

In a position statement, AAMC said every patient should have access to a medical home, meaning a continuous relationship with a health care provider or team of providers to help him or her navigate the health care system.

A recent survey of patients in the United States and six other countries, meanwhile, indicated that patients who have a medical home are less likely to report shortfalls in care coordination than those who don't.

The Commonwealth Fund study found that only 50% to 60% of adults across the countries surveyed have a regular physician or source of primary care that is easy to contact by phone, knows their medical history, and helps coordinate care — key attributes of a medical home.

In the United States, insured adults under age 65 were twice as likely as their uninsured peers to have a medical home. U.S. patients were more likely than those in Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom to report cost-related barriers to care, reflecting "cost-sharing as well as high rates of uninsurance," the authors said.

In its statement, AAMC said payment for the model should appropriately recognize and reward providers for prevention, care delivery, and coordination, and that providers should be trained to understand and implement the model within a team environment. ■

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