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Growing Role for Patient Access: Payer Contract Negotiations

Most patient access leaders do not spend much time thinking about contract negotiations between the hospital and health plans. "It's not something they traditionally were asked to play a role in," explains **Peter Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Healthcare in Atlanta.

Some hospitals end up agreeing to terms that hurt the revenue cycle. "Patient access departments feel the good and bad consequences of contract provisions every day," Kraus observes.

Authorization time frames are the most notorious example. "Patient access departments often are responsible for ensuring that front-end contractual provisions are met," Kraus explains.

Some of the most troublesome contracts allow payers to take up to 14 business days to give an answer. Waiting that long wreaks havoc with productivity and patient satisfaction. People blame the hospital, not the payer, for taking so long to make a decision on the authorization.

"If provisions are infeasible, ambiguous, or contradictory, patient access is set up for failure," says Kraus, noting better agreements with health plans make it much easier to financially clear accounts. "It is best, though not always possible, for hospitals to negotiate similar contracts with all its payers." Otherwise, patient access staff scramble to keep track of all the different requirements.

There are two other items likely to cause headaches:

• **Sometimes, payer contracts include requirements for data that are not always known at the time of scheduling.** "Access should not be expected to produce information to payers that physicians are not expected or required to provide," Kraus offers.

• **Other times, payers require data that simply cannot be met with available staffing.** Some payers require data provided by a utilization review (U/R) nurse in the ED, even during weekends and night shifts. "This is regardless of whether such staff are available 24/7 — or maybe even whether the payer can respond at all hours to such calls," Kraus says.

Input from patient access on all these matters is a game-changer. "It protects the facility from accepting front end-related requirements that are impractical to meet," Kraus says.

Patient access leaders may be the only ones in the entire hospital with the expertise to spot problematic requirements. Kraus says including them in the process

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SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jason Schneider
EDITORIAL GROUP MANAGER: Leslie Coplin

"is part of acknowledging the ever-expanding importance of front end participation in the revenue cycle."

Typically, the managed care or finance department handle negotiations with payers. But patient access knows which terms are going to make it difficult for the hospital to obtain reimbursement. "Managed care contracts should fully spell out requirements related to payer notifications, payer responses, and required data," says **John Woerly**, MSA, RHIA, FHAM, an Indianapolis-based revenue cycle consultant.

Often, patient access is out of the loop on these specifics. "Many times, leaders are not part of the negotiations nor made aware of expectations," Woerly notes. "Patient access must be at the table and provide input."

Unrealistic requirements on the hospital side inevitably cause denials, but it works both ways. Payers are required to handle certain things, too. "Many times, contractual agreements are not adhered to because the providers don't have the mechanisms in place to ensure payer compliance," Woerly reports.

Sometimes, neither patient access nor payer staff truly know the requirements as stated in contracts. If payers are not meeting their obligations, patient access should not hesitate to call them out on it, Kraus offers. "The department should provide ongoing documented feedback to contract management and denial teams," he says.

Woerly suggests patient access share these data with whoever is negotiating payer contracts:

- Volume of claims denials and write-offs (both dollar amounts and percentages);
- Reasons for denials (medical necessity, no authorizations in place, etc.);
- Whether the payer is meeting payment time frames.

"It is essential that the provider monitor such data and hold the payer responsible, just as the payer will hold the provider accountable for items documented in the contract," Woerly stresses. For this to happen, the revenue cycle needs to be involved. "This ensures compliance, realizes appropriate financial outcomes, and meets patient expectations," Woerly adds. ■

Patient Access Leaders Tell Important Stories at Conferences

Unlike many clinical experts, patient access leaders may be viewed by hospital leaders as operating mostly "behind the scenes."

Presenting at conferences is a great way to change that outdated perception, says **Elizabeth Reason**, MSA, CHAM, CBCS, National Association of Healthcare Access Management (NAHAM) conference planning committee chair.

• Submit a proposal for a "Learning Lab" session. "Maybe they've had an innovative project at their facility and can present on that," says Reason, patient access director at Lake Huron Medical Center in Port Huron, MI.

NAHAM changed its Learning Lab format at its 2019 annual conference by adding "Lightning Learning Labs." Previously, Learning Labs were presented in 90-minute increments. The new format allows for some 45-minute sessions so more topics are covered. "It allows newer speakers

to focus on a short, hands-on style presentation," Reason adds.

Shorter sessions are less daunting and more personal. "The hands-on approach allows the speaker to really connect with the audience as they share their patient access story," Reason observes.

• **Partner with a technology leader.** Together, patient access leaders and vendors can tell a story on how the department boosted point-of-service collections, patient satisfaction, or efficiency. "We love it when people have stories to tell about something they did, whether it worked or didn't work," Reason says.

• **Create an interesting webinar idea.** This is an easy way for patient access leaders to get their foot in the door, and gradually work up to presenting at conferences. **Kirsten Shaffer**, CAE, NAHAM's executive director, says, "NAHAM is always willing to consider webinar ideas. It's a lower-pressure avenue."

• **Join a group of presenters.** When the conference committee encounters several proposals with the same broad theme, they evaluate it for possible panel presentations or preconference symposiums.

"If people haven't had a lot of speaking experience, we can pair them up with somebody who does," Reason reports.

• **Develop speaking skills within the department.** "Some people have a great topic to present, but they are nervous about doing it," Reason observes.

The patient access department devised an alternative way to help staff gain public speaking expertise. At the annual staff meeting, members from each area deliver a short presentation as part of a team. "Staff often stated that they didn't understand what was different about various other patient access areas," Reason notes.

To clear up confusion, a few employees from each area were asked to talk briefly. The presenters, many of whom have never spoken publicly, talked for five or 10 minutes at the most. "Partnering up with somebody is a little easier," Reason says. "It takes the fear factor away." For Reason, speaking at conferences sparked success in the field.

"Early in my career, I had opportunities to present locally, then nationally, and grasped them. If I hadn't, I probably wouldn't have been where I am today," Reason says.

Good speakers soon find themselves in high demand as subject matter experts. "We share a lot of information. We'll call a colleague and ask if they know someone with expertise in a particular topic," Reason explains.

NAHAM's annual conference covers a broad range of topics, ranging from leadership in patient access to software implementation and process improvements. "One of the things we saw this year were a lot of presentations on diversity and inclusion," Reason reports.

The conference committee reviewed about 70 proposals, assigning scores for innovation and relevancy. Not all were selected, but Reason encourages perseverance: "If it doesn't happen the first time, keep trying." ■

More Patients Newly Eligible for Medicaid; Many Unaware

When uninsured or underinsured patients need help at St. Luke's Health System in Boise, ID, they will find plenty of options. "Our goal is to connect them with any available resources to alleviate their balances," says **Rachel Seaman**, director of the patient access resource center. These include many different federal, state, and county programs.

Up until recently, Medicaid usually was not one of the available options. Currently, 36 states and Washington, DC, have adopted Medicaid expansion, and 14 states have not.[1] Idaho recently expanded Medicaid coverage, making about 90,000 Idahoans newly eligible. "Before Medicaid expanding, it was pretty difficult for an adult to receive Medicaid," Seaman says. "Now, more of our population will meet income criteria."

Patient access is helping eligible patients enroll. "Those who had insurance are not losing it. Those who had no insurance are now gaining it," Seaman reports. "We've got a pretty big initiative to help community members get enrolled if they're eligible." Here are more details about how St. Luke's is helping patients enroll:

• **Staff look for all types of coverage the patient is on currently, including commercial insurance and Medicare.** This happens for all patients who are admitted without insurance.

"It's not uncommon that we have to do some discovery and some research before we talk to an uninsured patient," Seaman notes.

Some patients are going from commercial insurance to Medicaid. Of this group, many never had any coverage before, and they received letters informing them about their Medicaid eligibility. Even so, some are unaware they are eligible and possibly even already enrolled in the program.

For those newly eligible, "there are less financial barriers to care. They can remain compliant with follow-up care

and medications because they have coverage they never had before," Seaman observes.

• Automated tools show what coverage the patient was under in the past, or is under currently (if any). Staff can tell if the patient is on Medicaid, was in the program in the past (and, if so, what type of Medicaid it was), or if the patient has ever qualified for the hospital's internal charity program.

"If they have current coverage, great — we add it to the account, and it goes through the regular billing process," Seaman explains.

If not, staff focus on figuring out how to help the person enroll in some type of coverage.

• Staff offer other options if someone does not qualify for Medicaid. The expansion covers only those with income up to 138% of the federal poverty level. If a patient does not meet this criterion, staff search for other help.

"Our internal financial care program is still available to anyone who meets the criteria and isn't eligible for external resources," Seaman notes.

Some pharmaceutical companies offer programs to assist with medication costs.

"We are also one of the last states to have the county medical indigency program," Seaman adds.

• The financial advocate team (all certified enrollment counselors) can help patients enroll in any existing Medicaid programs, or the new expanded Medicaid. Applications are a long and complex process, especially if someone is not feeling well. "It's not uncommon to misunderstand what paperwork is needed and where to take it," Seaman notes.

Various programs list different requirements. For example, Idaho Medicaid does not calculate assets in determining eligibility, yet the application asks for bank account and real property information. Well-trained staff can help sort these details.

"The financial advocates handle it all during the admission," Seaman says. "The patient doesn't have to worry about it." ■

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Missing Clinical Documentation Reason for Many Claims Denials

More health plans are asking for certain pieces of clinical documentation before paying claims, according to **Rajiv Sheth**, director of Navigant's revenue cycle management consulting team. If it is not there, the claim is denied. What are the specific issues arising?

• Health plans want to know the patient has tried cheaper alternatives before approving surgery. "Payers want evidence the patient has completed a specific amount of time on 'conservative treatment,'" Sheth says. They often want proof the patient tried physical therapy or medications before surgery.

• On the inpatient side, payers are denying claims because provider documentation is either not a definitive diagnosis or does not support severity. The use of terms such as "likely," "impending," and "suspicious for" are causing payers to question necessity, Sheth observes.

• ED services may be denied for nonemergent diagnoses. This might be for something such as an upper respiratory infection.

• Payers are denying claims because documentation does not support the diagnosis. A common example is a dehydration diagnosis, but the patient was treated with short IV infusion, and is on oral intake the next day. Payers also deny claims with a sepsis diagnosis if labs or cultures are within the normal range.

• Payers are denying short stay inpatient bills. The health plan claims the patient could have been treated in an outpatient setting. Case management or use management nurses can help with this by ensuring inpatient admission orders support the patient's status as an inpatient.

Not all claims denials give a specific reason, making it difficult to correct. "Patient access should be prepared to receive denials with incomplete or insufficient explanation from the payer," Sheth cautions.

Health plans are scrutinizing coding, says **Shela Schemel**, senior vice president of Navigant's business process management team. Claims are returned for reasons such as "bilateral diagnosis not used" or "incorrect laterality with procedure."

Even claims that are denied for "medical necessity not met" often can be traced to incorrect coding.

"Many times, this is still coding," Sheth reports. "Incorrect coding can create a domino effect of payer denial reasons."

It would be easiest for patient access to submit all relevant clinicals at the same time as the claim. Health plans use a different process.

"When it comes to clinical documentation, payers don't always want all that paperwork up front," Sheth

explains. Instead, a back-and-forth process is used. First, payers receive the claim, then they request medical records (if necessary).

To avoid payment delays and denials, Sheth recommends compiling all clinical documentation so it is ready to go. "Anticipate that payers will request it at any time," Sheth says. Also, add a note to the claim stating, "Additional information available upon request." With good clinical documentation, many denials can be appealed successfully.

"They are hoping you don't fight them back. Don't just accept the first denial if you believe the claim should be paid," Sheth advises. ■

Payers, Hospitals Disagree About Whether Patient Meets Inpatient Criteria

Payers are refusing to pay claims for gastric bypass, joint replacement, and even cataract extraction. Why? Because documentation in the record does not support the need for surgery.

"We are certainly seeing an increase in denials for medical necessity," says **Ronald Hirsch**, MD, FACP, a physician with Chicago-based R1 RCM Physician Advisory Solutions. The denials fall into two categories:

• Unscheduled patients who present to the ED and require hospitalization. "Many denials are issued for inpatient admissions where the payer felt a lower level of care was warranted," Hirsch explains.

Payers insist the patient did not meet criteria for inpatient status and should have been treated as observation during the hospital stay. Obtaining the correct payer information is the first step in avoiding problems. "At every step, the payer source will be needed," Hirsch stresses.

It all starts with determining the correct admission status. Payers use varied criteria to determine if a hospital stay is warranted. For instance, Medicare uses the "Two-Midnight" rule, requiring a hospital stay to cross two midnights to meet criteria for inpatient admission. "Other payers use myriad different methods," Hirsch reports.

If the payer information is wrong, there is no way to ensure the admission is authorized. "Denial is likely for lack of notification," Hirsch adds. Even more problems can arise during the hospital stay. "Payers will often authorize a set number of days for the admission," Hirsch says.

If it turns out the patient is not ready to be discharged after all, the hospital must provide updated clinical data to justify it.

"If that information is not provided within the payer's arbitrary timeframe, the hospital may receive a partial payment, or see the whole stay denied," Hirsch warns.

• Elective patients with scheduled hospitalizations. Payers are steering as much care as possible to lower-cost settings. Increasingly, they are refusing to pay for hospital-based procedures and refer patients to physician's offices or ambulatory surgery centers. "If the procedure is safe to be done in that setting, they want it done there to save money," Hirsch explains.

Solid documentation is needed to support the need for the procedure to be performed in the hospital. For example, it is true that some elective laparoscopic cholecystectomies can be performed safely in surgery centers. However, not all fall into this category. One example is patients with sleep apnea who are at increased risk of respiratory compromise.

"Safe practice would be for that patient to have surgery at the hospital," Hirsch says. "But unless that is documented in the notes, that crucial information cannot be conveyed to the payer."

The surgery itself is no different, whether it is performed as an outpatient or inpatient procedure. "It's the same surgeon, same nurses, same OR, same implants, same recovery," Hirsch observes. "The status is really all about payment."

Sometimes, the payer approves the surgery to be performed as an inpatient procedure. Then, the hospital submits an outpatient claim, or vice versa. "It will be denied, even though the surgery went well, and the patient recovered," Hirsch notes.

Conflicting documentation on the patient's status (i.e., outpatient or inpatient) causes problems. "Close communication between the payer, the doctor, and the hospital, to ensure everyone uses the same status, is important," Hirsch adds.

Even if all this is executed perfectly, payers still can dispute the claim on medical necessity grounds. On this point, payers argue the patient really did not need to undergo surgery, receive a pacemaker, or undergo chemotherapy.

Payers are asking specific questions, such as: What has been tried prior to surgery? What alternatives were discussed with the patient? Does the care match the guidelines for treatment of that condition? "Much of this requires someone with clinical knowledge," Hirsch says. Ideally, patient access works with use review nurses to schedule

surgery. It is a problem when surgeons bypass the process altogether, simply calling the hospital, giving a patient name, and placing a surgery on the schedule. This long-standing practice, "should no longer be acceptable," Hirsch offers.

First, the documentation needed to support the medical necessity of the surgery should be in place. Then, patient access can compare the payer guidelines to the clinical documentation. "If the guidelines are not met, further action is required," Hirsch explains.

Otherwise, the payer is going to deny the claim. To bring physicians on board with these practices, patient access needs support from hospital leaders.

"The first time the doctors are told they can't schedule a surgery unless they send office notes, they will storm into the CEO's office complaining," Hirsch predicts. Once administrators realize the financial implications, they will understand that revenue is lost if doctors schedule their patients directly.

"The CEO needs to know why the doctor is being asked for the information so they can support the patient access process," Hirsch says. ■

Some Patients Present With 'Hidden' Insurance Coverage; Patient Access Can Uncover It

Certain patients who say they do not have any insurance actually are covered in some way. It is the job of patient access staff to find it — and avoid uncompensated care for the hospital.

"Hidden revenue is always good revenue," says **Cheryl Barrett**, patient access director at Parkland Health & Hospital System in Dallas.

Regardless of whether patients are unaware of their coverage, or withhold the information on purpose, some detective work is needed. This is where the hospital's financial assistance policy comes in handy.

"It should require patients to cooperate with applying for any potential insurance coverage," says **Valerie A. Rinkle**, MPA, CHRI, president of Valorize Consulting, a Medford, OR-based firm specializing in revenue cycle management.

Efforts on the part of patient access to find coverage can decrease bad debt. "Usually, the total is reduced by investing in more comprehensive and better upfront processes," Rinkle notes. The following are certain cases when people present as self-pay when they actually do have some type of insurance coverage:

• Some people do not admit they have insurance, only because they do not want to pay their deductible. The hospital's discounted self-pay rate could end up lower than a high-dollar deductible.

"As a result, patients consider themselves self-pay instead of sharing the insurance information," Barrett explains.

Many underinsured patients still cannot afford their out-of-pocket costs but assume the fact they do have insurance disqualifies them from receiving financial assistance. That is not always the case, since policies typically apply to anyone with out-of-pocket expenses they cannot afford.

"Even if their deductible is $7,000, the hospital may determine the patient does not owe this amount due to financial need," Rinkle says.

• Patients may have tried to obtain coverage at some point, but lost track of their enrollment status. "We have found this to be the case with patients who are transient," Barrett reports. Some patients completed forms electronically using an email address they can no longer access. Other patients lost paperwork during a recent move.

• Patients with injuries do not know their medical expenses are covered by third party liability insurance. Some do not realize their employer provides workers' compensation insurance. "Patient access needs to perform a thorough intake of patients to determine any potential coverage for injuries, even if the visit is not on the same day as the injury," Rinkle stresses.

• Newly hired patients do not realize their coverage is effective already. One Parkland patient said he had not been on the job long enough to receive health insurance. Patient access staff found out that coverage started on the first day of employment.

"In most cases, patients are not educated on their coverage," Barrett laments.

• Patients who recently left a job assume they have no coverage. Many believe coverage ends on the date of resignation, termination, or retirement.

"However, the end date of your health insurance may differ from the employer's termination date," Barrett says.

The same applies to many plans purchased on the Health Exchange Marketplace. "The end date normally has a grace period in which the insured is still covered," Barrett adds.

• Patients with chronic conditions, including cancer, may qualify as disabled. "This immediately qualifies them for coverage under their state Medicaid program, and may also

provide a monthly income," Rinkle reports.

After two years, the patient would qualify for Medicare coverage. People do not always apply for disability coverage. "There may be stigma or a concern that it is too hard to apply," Rinkle says. Looking at the diagnoses of patients seen repeatedly can identify people who are likely to qualify for disability.

• **Divorced patients do not realize they are still covered under a spouse's insurance plan.** One man told registrars he had no insurance, was not employed, and was a stay-at-home parent. When staff asked how he was paying his bills, he said his family was helping out after a divorce. Staff asked the patient if he had been covered under his spouse's insurance. The answer was yes, so staff followed up with the spouse. "He was actually still covered under her insurance plan, but thought that she'd removed him since the divorce was finalized," Barrett says.

To ensure any coverage a person has is identified, information is power. "We depend on intuitive technology and employee interviewing skills to find healthcare coverage," Barrett notes.

The tools can shed light on the person's address history, coverage history, and credit history. Barrett says registrars need to ask detailed questions.

"The same screening questions need to be asked each and every time the patient presents for service," she stresses.

Sometimes, a surprising piece of information comes from the clinical side — a case manager, nurse, or social worker.

"There is a higher trust factor between the patient and the clinical partner," Barrett observes.

Patients may share something with a clinician they do not tell the financial team. One 72-year-old patient presented with an extended illness. He said he never applied for Medicare, was self-employed, and did not have any emergency contacts.

However, a social worker revealed that when the man was about to leave the hospital, he mentioned his sister would assist with post-discharge care.

"We contacted the sister to determine the coverage history. She didn't understand why he didn't have coverage because he was a veteran," Barrett recalls.

Registrars investigated further, and learned that the man was covered, but had never used the service.

"The patient said that he didn't recall that he was eligible for VA services," Barrett says. ■

Online, Classroom, Team Huddles: For Training, All That (and More) Is Needed

The amount of needed education for patient access is only increasing. "With constant changes in both work and regulatory environments, there is a need for consistent training for both new hire and current employees," says **Drew D. Totten**, principal administrative analyst for patient access services at Los Angeles-based Ronald Reagan Medical Center.

To keep up, multiple education approaches are needed. Totten's department uses three approaches:

• **Online training.** This does not work for some subject matter.

"But there are several topics that can be delivered effectively online," Totten says.

Staff use online modules on new hire work rules, radiation safety, patient privacy regulations, sexual harassment, and cybersecurity. Distraction is the biggest downside when training is conducted online.

"Interruptions disrupt the flow of the training and may impede the employees' ability to understand the material," Totten observes.

On the positive side, online modules help with productivity. "It frees up time for the managers so they can focus on the day-to-day operations," Totten adds.

• **Classroom training.** Complex patient access topics are not well-suited for the online model. Such issues are covered in the traditional classroom setting instead. "These are very intricate and detailed, requiring the employee's complete attention," Totten explains.

Financial counseling, insurance verification, and collections are good examples. "Patient access trainers can assess employees' understanding in real time, and make changes to how they're presenting the information," Totten reports.

• **A "Train-Do" model.** This approach has been extremely successful, according to Totten: "Our best practice is to have the employee complete a training course, then immediately apply the newly learned skills," he says.

With this "Train-Do" model, people become truly proficient. "Each employee is trained identically," Totten says. "The skills are applied while the information is still fresh."

For complex tasks, managers monitor the employee's work closely. This includes admitting a patient from the ED. Depending on the reason for the admission and the insurance, there could be dozens of steps in the registration process. It starts with greeting the patient; it ends with their admission into the hospital. "We want to ensure each employee follows each step accurately," Totten stresses.

Confirming or obtaining details on demographics, insurance, financial liability, and all kinds of documentation are involved. To be sure it is all handled correctly, managers periodically review five ED admission cases at random. "This reduces workflow errors, saves time on retraining, and decreases claim denials," Totten says.

The patient access department at Cambridge Health Alliance in Malden, MA, uses online training for the following:

• Introducing new hires to the revenue cycle;

• Using the department's real-time eligibility verification system;

• Completing unique registrations, such as people who want to remain confidential or those involved in motor vehicle and industrial accidents.

"Now that we are on one system, we are beginning to get reports on denials or registration errors," says **Maryann Heuston**, senior director of revenue cycle access operations.

Leaders can trace a denial to see whether it began at the point of scheduling or registration.

"We can ask ourselves questions like, 'What is causing $500,000 worth of denials? And how can we tackle it with training?'" Heuston reports.

If an employee is prone to a particular mistake, he or she is asked to sign up for an online course. This allows for quick, targeted training, as many times as needed, for that employee to become proficient. "That is very useful because you don't have to pull someone into a classroom," Heuston observes. "They sign up for the course, and don't have to leave work."

The department is now looking for a resource for creating some additional online training. Currently, it is handled by a trainer on the clinical side.

"We talked about possibly outsourcing the creation of these courses. But we want to keep control of managing and updating them," Heuston says.

The Cambridge system includes three hospitals and 30 ambulatory clinics spread out over three cities. "You have to get a significant amount of information to a varied audience," Heuston notes.

Online training helps with the sheer amount of information that needs to go out to about 400 front-end registrars.

"It's a way to get information down to the front-end user without having to take them out of their work location to a centralized training center," Heuston explains. ■

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