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Retain your staff in a world where other jobs pay more

Here are ways to motivate longtime employees

Recruiting quality patient access services associates in this tight job market requires persistence and ingenuity. Employees know there are plenty of jobs out there that pay more for less demanding work. As one veteran access manager says, workers can serve bagels for close to the same pay and a lot fewer hassles.

In access management, frontline employees grapple with convoluted insurance requirements. They must sympathetically yet firmly discuss financial responsibilities with incoming patients. It's not easy, and it's small wonder that good registrars are hard to find.

The challenge of recruiting and retaining good workers is a dual one, says **John Woerly,** RRA, MSA, CHAM, a longtime director of access services who is now a manager with Cap Gemini Ernst & Young in Indianapolis specializing in patient access redesign. Too often, Woerly notes, employees who meet and exceed their goals lose their incentive and are lured away by other organizations or other departments within the hospital.

"If the pay range is $9 to $11, and they've been capped out at $11 for the past two years, they may say, 'Why should I kill myself to perform at a higher rate when it goes without a salary increase? I want to stay in this department, but I could go elsewhere for a better salary.'"

It's important to realize, he says, that it costs more in the long run to recruit and train new

Also in this issue: Results of *Hospital Access Management*'s 2000 reader salary survey

COMING IN FUTURE ISSUES

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employees than it does to provide financial incentives for existing employees. "As new staff go through the learning curve, the department's data integrity may also suffer, resulting in rework and potentially negatively impacting accounts receivable [AR] days."

At one organization where he implemented an incentive program, Woerly adds, the program was not budgeted as a separate line item. He simply estimated that if the program cost $10,000 a year, for example, that amount would be recouped — in unspent advertising, interviewing, and training expenses — by the retention of two or three employees who otherwise would have left.

Incentive plans benefit an organization in two ways: They help recruit quality staff, and they stand out when compared with competitors' pay systems, Woerly points out. "The plan we put in place recognized performance, quality, customer satisfaction, and productivity. It looked not only at the individual, but at the group."

Woerly outlines three plans he has used to enhance staff performance:

1. **Quality and productivity bonus.** Employees in access areas such as customer service, preregistration, registration, and ambulatory scheduling received points based on improvements in various categories, each of which was assigned a different weight.

Group goals included reductions in AR days, queue wait time, call abandonment, and increases in upfront collections, among other things. Employees were rated individually in such categories as productivity and monthly quality standards. Depending upon their scores, employees could receive bonuses ranging from $50 to $150 each month. **(See tables, p. 123.)**

Amounts the access manager designated varied, of course, depending upon available funds, Woerly points out. "It could have been $20. It's really just the matter of recognizing the individual effort. Surprisingly enough, the sheer symbol of recognizing high performance was a tremendous morale booster. It affected the associate who was already achieving and established a higher bar for others who had the opportunity to enhance their performance. Additionally, it made the standards come alive."

2. **Overtime for focused initiative deployment.** This plan was put in place at a time when the hospital was implementing improvements in the emergency department (ED) process, including

Quality and Productivity Bonus — REGISTRATION

KPIs	*Base*	*5*	*6*	*7*	*8*	*9*	*Weight*	
							OP	**ED**
Monthly Quality Std (Personal)	75%	80%+	85%+	90%+	95%+	100%+	35%	35%
Discharge Financial Education Demographics Changes (86th Express Care)	100%	80%	85%	90%	95%	100%	0%	5%
Upfront Collections (86th Express Care) % of Amount Due	50%	70%+	80%+	90%+	100%+	100%+	0%	20%

Quality and Productivity Bonus — BUSINESS OFFICE

KPIs — Registration	*Base*	*5*	*6*	*7*	*8*	*9*	*Weight*
AR Days	85	80	75	70	65	60	5%
Productivity (Personal)							30%
Cost Per Unit of Work	$6.20	$5.90	$5.60	$5.30	$5.00	$4.70	10%
KPIs — Pre-Registration							
AR Days	85	80	75	70	65	60	5%
Monthly Quality Std (Personal)	55%	80%+	85%+	90%+	95%+	100%+	35%
Uninsured Patient Referrals to F/C	0%	10%+	20%+	30%+	40%+	50%+	10%
KPIs — Scheduling							
Call Abandonment (Team)	6.5%	6.0%-	5.0%-	4.0%-	2.0%-	0%	2.5%
8 Points of a Good Call	100%	80%	85%	90%	95%	100%	10%
Medical Orders Processed	70%	80%+	85%+	90%+	95%+	100%	15%

SAMPLE…

Associate 1 works in Customer Service and achieved the following quality and productivity levels:

KPIs	*Base*	*Rate Achieved*	*Weight*	*Score*	*Total*
AR Days	85	75	5%	6	3
8 Points of a Good Call	100%	95%	20%	8	16
Cost per Unit of Work	$3.25	$2.90	10%	5	5

discharge coordination, bedside registration, and quality assurance and training.

"We needed extra registration bodies in the ED to assist in a smooth transition," Woerly explains, "but not all staff within the department were cross-trained. Cross-training was not an expectation prior to this time. Staff were very specialized and were not fully trained to work in other areas within the department."

The overtime incentive plan included:

• Staff received a bonus of $2 per hour for working hours above the normal workweek (36 to 37.5 hours for full-time associates and 36 per two-week pay period for part-time associates) or additionally assigned hours as designated by management. That differential was in addition to the standard overtime rate for hours worked over 40 per week and evening / night / weekend differentials.

• Management decided which individuals were approved for the bonus plan based upon associate performance and organizational goals.

• To qualify for additional assignments, employees had to meet minimum productivity and quality standards for each category of tasks.

• Overtime was approved for targeted jobs as determined by management.

• An associate's regular manager had to approve a request to work overtime in coordination with the patient intake team leader so it didn't interfere with the associate's regular job assignments.

• The patient intake team leader was responsible for establishing the number of associates needed and hours required, for training and competency validation, and for productivity / quality and outcomes reporting.

• Overtime limits were not to exceed 20 hours per week for a total of no more than 60 total hours worked per week.

3. **Staff recruitment incentive.** Employees who helped recruit another staff member received a monetary bonus after the new employee had performed the job successfully for three months.

Although the hospital had used several other ways of finding staff, this method brought the best results, Woerly says. "We had recruitment agencies looking for staff, had a job fair **[see related story, below right]**, and had talked to the deans at community colleges. But we found that if our people recommended a friend or a cousin, they're motivated to want that person to succeed and also will assist in training to help make that happen."

Before leaving that organization, he notes, "I signed off on six or seven [recruitment bonuses] departmentwide over a three- or four-month period."

Participation in the various incentive plans, whether assisting in staff recruitment or working unscheduled overtime, also figured into employees' annual evaluation and contributed to salary increases, Woerly adds.

Despite the frustration access managers sometimes feel when their best employees go on to bigger and better jobs outside their departments, it's a good thing to assist in employees' "career-building," Woerly maintains. During his various tenures as access director, he identified and encouraged a number of employees who advanced in their careers, many of them within the access department.

"One [access employee] had an interest in computers and an organized process mindset," he recalls, "and I told her she had the talent to work as a system administrator."

The woman expressed a need for more computer training, which Woerly arranged. She now serves as a system administrator at that organization.

"Be aware of people who have potential and assist them," he recommends. "It's a matter of not settling for the mediocre as you're hiring. Hire with the idea of allowing that person to gain knowledge and experience. Provide vehicles like training and attendance at meetings of professional organizations to build their skill set and allow staff to move up."

Even those who move on to other departments can provide a benefit to access services by enriching the knowledge about patient access in their new jobs, he says. Woerly cites another access employee who went on to become an executive secretary to the institution's chief executive officer. Another associate received training in radiology and is now director of that service.

"When issues or problems came up [regarding access services], both individuals could say, 'I worked there, and I know why they do that,'" Woerly says. "These people can be positive communicators and supporters for your department."

[Editor's note: Hospital Access Management *would like to publish your staffing solutions. Please contact editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com to share ways you've found to attract qualified staff and keep them happy.]* ■

Access job fair brings fast results

HR helps speed process

Facing a low unemployment rate in your geographical area at the same time you're desperate for an infusion of new employees? Try hosting a job fair.

That's the solution **John Woerly,** RRA, MSA, CHAM, and his management team devised when the hospital where he served as director of patient intake needed to increase its access staff in a short period of time.

"We were creating new functions, establishing upfront collections and bedside registration, and were putting in an Advance Beneficiary Notice process," explains Woerly, now a manager with Cap Gemini Ernst & Young in Indianapolis. "We were going from a decentralized operation to a more centralized one, so we were going through rapid change, which created new positions."

To publicize the job fair, he says, Woerly advertised in the local newspaper and on the local radio station, announcing that applications would be taken between 5 and 7 p.m. on a particular day. "We had rooms set aside for keyboard skills assessment, human resources people there to get applications filled out, and our entire management team on-site."

More than a dozen managers attended

Between patient intake and patient financial services, which joined in the effort, some 12 to 14 management personnel were present, he notes. All available job openings, with hours and necessary qualifications, were posted, and a four-person panel, including Woerly, screened each applicant.

"We asked about their background, areas of interest, and the hours they preferred," he says. "I might say, 'I don't have these hours available within my department, but financial services does.'" Following the screening, another manager would conduct a more in-depth interview, he adds.

He had arranged in advance that human resources personnel would speed up drug testing / physicals and checking of references, "so instead of taking two weeks, it was done within the week."

As a result of the job fair, about 20 people were hired, he notes. "Before that, if we could hire three or four a month, we were doing well."

Physicians as registrars?

Access managers in a community with a medical school might want to try a recruitment strategy he used at another facility, Woerly suggests.

"When I was in a university setting, one of the [educational] criteria for medical students was that they work a semester in a hospital, preferably in a nonclinical setting," he says. "We hired four or five interns and residents and employed them in patient scheduling and preregistration."

Woerly says he discovered that these physician / registrars were extremely computer savvy and could be trained in about one-fourth the time of the average new hire. As an added benefit, "when they become full-fledged physicians, they'll have a better appreciation of what [access personnel] do and how we do it," he points out. ■

Management's got a brand new bag

Rewarding staff doesn't have to cost you

In the years he's spent overseeing access personnel, **Anthony M. Bruno**, MPA, has made something of an art out of motivating and rewarding his employees, often with group-oriented recognition and events.

In his latest innovation, Bruno, director of corporate admissions and registration at Crozer-Keystone Health System in Upland, PA, focuses on individual excellence and providing his managers and supervisors with some ways to recognize it. "We already do group things," he adds. "Now we want to come up with ways and reasons for rewarding and recognizing more personal achievement."

The program, which Bruno has dubbed the "Recognition and Reward Tool Bag," is not meant to replace bonuses or salary increases, he says, but simply to tell the employee, "I appreciate you and what you've done." The emphasis, he notes, is on recognition, not reward.

When to brag

That recognition could be for an employee who has come through a stressful period and completed a difficult work assignment, or simply for someone who has a positive attitude, Bruno says. The recognition might come in the form of a smile, a pat on the back, and a simple thank-you, he adds. It also could be a personal letter to the employee, with a copy to his or her immediate supervisor, Bruno notes. The recognition can extend, he says, to having a system vice president make a presentation to employees who have gone the extra mile. That was the case, Bruno adds, when some staff members worked particularly hard during a recent computer shutdown.

The actual rewards in the management staff's tool bags are really token awards, he says. "Nothing in the tool bag costs more than $7. These are items like a note card that says, 'Thanks for helping me out' and a pack of Lifesavers with 'TEAM: Together Everyone Achieves More' on the label."

The bag also includes Post-It notes, with sayings like "thanks," "wow," and "applause" as headings, and foam stress-relief toys, such as a heart that's labeled "star," Bruno adds. The company

that sells many of these items, Baudville Inc. in Grand Rapids, MI, also offers software that allows managers to design their own awards, such as a team-player certificate, which can be placed in an inexpensive frame and presented to a deserving employee, he notes.

Don't assume managers and supervisors know how to recognize employees in this way, Bruno advises. "Some supervisors normally say, 'Good morning. How are you?' and with others, you can't seem to get a nice word out of them."

"Recognizing accomplishments, building self-esteem, and being sensitive to individual qualities help release the energy of self-motivation."

Rather than single out the ones who weren't up to par, Bruno says, he decided to offer a one-hour inservice program for the entire management staff, which includes about 40 directors, managers, and supervisors from four hospitals and a community mental health facility. Together, those people oversee more than 300 employees.

During the inservice, he says, "we'll go over not only the items in the tool bag but also how important it is to get employees to recognize each other. And we'll stress that after they're successful at doing this, they should continue it."

The idea, he says, is for managers to incorporate the program into their routine, "not just for a week or a month, but every day." So far, the response from his management team has been good, Bruno says. "It hasn't been a hard sell, as in, 'Oh, no. They're asking me to do something else,' but rather, 'I can use this.'"

The Recognition and Reward Tool Bag is one more effort that Bruno hopes will contribute to his goal of instilling in employees what he calls a "driven by team success" attitude, he notes. "What I want to see is employees recognizing other employees, getting them to realize that 'it's not about me; it's about us.'" With that in mind, he may provide tool bags for frontline staff in the future.

Bruno says the program stresses these ways of recognizing and rewarding appropriately:

- Offer recognition in an appropriate setting and be sure to make eye contact.
- Be sincere in your praise and make clear what behavior or action you are praising.
- Start each staff meeting with a public "thank you" or a solicitation for one.
- Walk the walk. Give support, cooperation, and collaboration to your staff.

At Crozer-Keystone, the recognition and rewards are being extended beyond the admissions and registration staff, Bruno notes, and not just to other departments. At a meeting of the physician billing staff, he says, an employee asked if the tools could be used to thank some of the physicians' offices that are particularly helpful in sending the information needed for a complete bill. Now, he adds, recognition is given to members of physicians' staffs when the two groups get together at breakfast and lunch meetings throughout the year.

The recognition and reward program is important because "people are the lifeblood of our health system, and people count on recognition," Bruno says. "Recognizing accomplishments, building self-esteem, and being sensitive to individual qualities help release the energy of self-motivation. The more people learn to be cooperative and collaborative, the better the working environment." ■

Newly built hospital 'more like a hotel'

There's no admitting department

It sounds almost too good to be true: a brand-new hospital that looks like an upscale hotel, with employees who are there because they're committed to provide not just customer service, but *compassionate* service.

From all reports, however, that is the reality at Woodwinds Health Campus in Woodbury, MN, a community hospital that is a collaboration of Health East Care System and Children's Hospitals and Clinics, both in Minneapolis.

"About five years ago, we decided to build a community hospital with a vision of being the innovative and preferred resource by creating an experience that has not been done before," says Woodwinds' chief executive officer **Julie Schmidt**, RN, MBA. In her case, she says, "CEO" stands for "customer expectations officer."

There is no admissions department at Woodwinds, which opened in August 2000, but rather a "fairly unique admitting process" whereby

patients go directly to the point of service, whether preregistered or not, says **Cara Hull,** executive lead of systems and process integration. The closest thing to an admitting office, Hull adds, is the one occupied by a single admitting coordinator.

Scheduling made simple

Patients are scheduled by a centralized staff — using Pathways Healthcare Scheduling, a product of Atlanta-based HBOC — that handles the function for all the sites that fall under the Health East umbrella and is reachable through one central telephone number, she explains. Bookings are created and sent to a Health East centralized preregistration staff, which calls patients to obtain or confirm demographic and insurance information, Hull adds.

"Once those patients arrive, they go directly to the point of service, whether radiology or a patient floor," she says. "There are still some pieces that need to be completed — forms signed and [a computer entry] that the patient is here — and that can happen in a couple of ways."

Information coordinators, located in every department and on every patient floor, can take care of those details at their desks or in the patient's room, using wireless laptop computers, Hull adds.

The admitting coordinator typically handles direct admissions, in which the entire registration process must be done after the patient arrives, she says. "She either does it in her office in the front of the hospital near the main entrance, goes to the department or patient room, or [takes the information] over the phone."

If the patient makes it to radiology without being registered, for example, there is a telephone alcove where he or she can sit and call the admitting coordinator, who is reachable by wireless phone, Hull notes. Volunteers are available, she points out, who don't just direct patients down the hall, but personally escort them. "That doesn't always happen, but we try."

The practice is part of the philosophy of customer service — "Compassionate Service at Woodwinds" — created specifically for the hospital, Hull explains. "There are specific behaviors: greeting the patient, looking up from what you're doing, making the patient feel he or she is the most important person."

Woodwinds is so serious about hiring employees who fit its purpose that it uses a behavioral assessment tool purchased from the University of Chicago Hospitals to screen applicants, says Schmidt.

"We try to create compassionate service by hiring the right employees and supporting them through the process," she explains. "They get a letter from me, stating the expectations, and they sign a "Compassionate Service Agreement."

Despite a pay scale that is "at market rate" and an unemployment rate in the area of less than 2%, Woodwinds had some 3,000 applicants for 400 jobs, Schmidt notes. "Some people were interested because we were close to home, but the majority wanted to work here because of the vision. We tried to let folks in the community know what kind of organization we're trying to create. There was excitement at being part of that new approach to providing care."

Woodwinds not only has a different feel than the average hospital, it has a very different look, she says. There is a two-story "town center" that connects the medical office building with the hospital. It features a grand piano, aquariums, a cafe, a retail shop, lounges, and five fireplaces and looks more like a hotel than a hospital, Schmidt says. All the patient rooms are single occupancy, with sleeping space in every room for family members.

Even with such amenities, she adds, construction costs per square foot for the facility are in the lower quartile of building costs throughout the country. "Sometimes, remodeling is more expensive than getting there in the first place," Schmidt notes.

'Easy way finding'

Because Woodwinds is situated on about 30 acres, parking is not a challenge, she says, and access to the building is pleasant and convenient. "When you arrive, there is a beautiful open area, with choices of where to sit."

There are no labyrinths or dark basements at Woodwinds, Hull says. "There is a main glass corridor that runs the length of the building. It's a two-story space, and you can see below. Whether you're going to radiology, cardiopulmonary, the lab, or surgery, you walk down one main hallway. It's like a street, with a sign at each corner telling where you are."

Easy "way finding," as it is called, was part of the building's design, she adds. "Our lowest level is the walk-out level, so there is no basement. You don't lose your sense of direction." ■

NOTES FROM THE FRONT

Putting access together again

Longheld notions re-examined

(Editor's note: ScrippsHealth in San Diego is in the midst of a massive redesign of its expense departments and front-end processes. Here's the latest in a series of occasional reports on the project.)

As ScrippsHealth continues its revenue cycle redesign, part of an overarching project called Scripps Team Achieving Results (STAR), longheld perceptions about the way business should be done are being scrutinized and, in some cases, discarded, says **Jack Duffy,** FHFMA, corporate director of patient financial services.

"It is really, really neat to take this whole thing apart and put it back together again," Duffy says. "Historically, we have created a situation that is not manageable."

Having consultants from Southfield, MI-based Superior Consultant Holdings Corp. as part of the team "doesn't allow you to take your ball and go home," he points out, something that often happens when different departments are asked to justify expenses and redesign their processes.

Bigger goal requires bolder reductions

What typically happens when an organization undertakes such a project is that it results in an incremental improvement in productivity of 5% to 10%, Duffy says. "That usually means a layoff and letting the survivors do the work."

With the goal Scripps has in mind — 30% improvement in productivity — those incremental changes just aren't enough, he adds. The plan is to reduce labor and service expenses by one-third in patient access, medical records, and the business office, Duffy explains. That effort, if carried by the labor component alone, would mean eliminating 100 of the 400 full-time equivalent positions in those three areas, he adds.

"We found out we had embedded some expensive business practices in our hospitals," Duffy says. "The most expensive was because we fell in love with 'patient-focused care.' In the cold light of day, access becomes hugely expensive when commingled with nursing secretary or other departmental duties."

In fact, he adds, Scripps has found that by combining positions in an effort to decentralize services, it pays a premium of 200% to 300% over what a focused department would cost. Meanwhile, he points out, "patients never commented that bedside administrative services were better than sliced bread. Some like it; some consider it an intrusion."

The Scripps redesign will affect access services in three primary ways, Duffy explains:

1. **There will be a return to discrete departments.** "The blended version, combining nursing secretary and other job descriptions with access, is not effective for access," he says. "There are significant issues with training. The [secondary access] employees fell behind the training curve because the managers had trouble releasing them for even brief training sessions." That meant the hospital had to back up those point-of-service employees with back-end rework, Duffy adds, which meant eligibility and authorization information often was obtained late.

When Scripps looked at the annual systemwide overhead associated with moving its 800,000 to 900,000 patients from the first point of contact through the conclusion of the billing process, it found the cost to be about $27.5 million, he says. "Only $18 million is in the centralized [patient financial services] budget, so that means $9.5 million is outside the direct control and supervision of finance."

An estimated 500 to 800 people split their time between access and other duties in their individual departments and spend as few as 45 minutes a day on access, Duffy points out. "When we track denials [of reimbursement], we draw some pretty startling correlations between those accounts and these part-time access people."

That strongly speaks to the wisdom of having regionalized specialty areas for registration — one for a campus, one for a building, or maybe one for a pod of departments — all of which are staffed by full-time employees, he says.

2. **Scripps will extract all the precare administrative services possible and move them to a call center, or "customer contact center."** "We don't believe it's possible to hit best practice production levels when you commingle a physical work queue with a telephone work queue," Duffy says. "The telephone work queue will never get done

and so will have to be reworked. That means a big chunk of this [registration] stuff goes all the way into billing with embedded errors. If you don't segregate the telephone work, you'll never reach the potential of electronic billing, HIPAA [Health Insurance Portability and Accountability Act] standardization, etc."

With this in mind, Scripps plans a customer contact center that it estimates will ultimately employee 35 people and perform some 1 million preadmissions annually, he says.

3. **Scripps will re-evaluate whether there will be a limited form of centralized registration to accommodate walk-in traffic.** Bedside registration will be an option, Duffy notes, but for the most part will not be necessary because the registration will have been handled in advance. Scripps also is considering the possibility of having electronic kiosks that will enable patients in ancillary departments to interact with an access employee at a central facility, he adds.

The patient accounts receivable cycle (PARC) that Duffy is charged with improving is one of three areas under the STAR project, which began in April 2000, he points out. Two other executive sponsors oversee clinical nurse processing and case management. A reduction of $6.6 million is expected in the budget for patient access, medical records, and the business office, from $18 million to $11.4 million, he says. "When you look at the outside departments [also involved in access services], the reduction is even more — from $27 million to $11.4 million."

Scripps estimates half of those savings will be achieved between October 2000 and September 2001, and the other half in the first six months of 2002, he says. "It's a neat, quite enlightening process. We look at tools and technology, but not until there is agreement on work processes. Work groups [on that subject] report to the hospital administrators every few weeks."

Issues to consider include whether a function will be managed by a single department or co-managed with dotted-line reporting, he says. "We put all the turf issues out front. Does registration report to the hospital administrator, or does it report to the corporate finance department? What we decided, in that case, is that because of all the training involved, it needs to be part of the central finance department."

Reserved as the sole responsibility of the hospital administrators, however, is the design and implementation of central scheduling, Duffy notes.

"We had two very long, tense meetings where we cleared the deck of any lingering issues regarding management structure, accountability, and process ownership, so we have a very solid foundation," he explains. "All the administrators [from hospitals in the Scripps system] are required to attend the meetings. It's very empowering. Without this, you're building on quicksand." ■

Electronic forms system replaces blue-card method

New system streamlines patient admissions

The old blue-card system for patient registration is fast becoming obsolete at Winthrop-University Hospital in Mineola, NY, where the three-year implementation of an electronic forms process is coming to fruition.

The 591-bed teaching facility now prints patient admission packets and other patient documents using the Patient Linkup Enterprise system from Standard Register in Dayton, OH, says **Amy B. Wolin**, MPSHSA, Winthrop's director of patient access services and president of the Hospital Admitting Officers Association of New York. The necessary forms automatically print based on the type of admission being entered by the registrar, she adds.

Rather than keep large inventories of preprinted forms that may become obsolete, the hospital now can print only the forms needed, Wolin says, and in most cases can eliminate the messy multi-ply forms in which the third and fourth pages often are barely legible.

"Through network printing, we've eliminated the number of printers needed at each location," Wolin points out. "We used to have separate printers for each type of preprinted form, including message sheets, multi-ply forms, labels, and registration documents. Now all documents are created from the laser printer, so the clerk is no longer required to retrieve forms from various bins."

After selecting the company's Patient Linkup Net system, Wolin notes, the hospital upgraded to Enterprise primarily for the following reasons:

✔ Enterprise runs on an NT server, as opposed to an NT workstation, and places no limit on the number of documents that can be printed. The Net software was limited to a maximum number.

✔ If Enterprise goes down, it can be brought back up without doing a check of every printer on the network, as is necessary with Link Up Net.

✔ Because Enterprise works off a network server, it doesn't require as many backup systems.

✔ With Enterprise, form changes can be made by a telephone call to the vendor. No one has to come on-site.

Winthrop started its implementation of the electronic forms system in the emergency department (ED), with registration and the ED clinical record, then expanded it to include all registration documents, Wolin says. "Now we've moved to putting all nursing clinical documents [on-line], which will complete the implementation hospitalwide."

Conquering the fear of change

The next phase, she adds, will be to look at the enhancements that are possible with Enterprise, such as electronically faxing documents to physicians' offices and insurance companies.

Before implementing its electronic forms system, Winthrop established a multidisciplinary task force to oversee the process, Wolin says. "There's fear of change and of changing documents, so we involved every department that touches a document." There were three key decisions that had to be made, she notes:

1. Define which documents will be brought on-line.

2. Determine in what packets, or outputs, those documents will print.

3. Decide where you want the documents to print, and on what "triggers."

For example, Wolin explains, there are medical packets, preadmission testing packets, and same-day surgery packets, each of which includes the forms needed by those particular patients. In the case of the same-day surgery patients, half the forms print in the registration area, and half in the same-day surgery area where the patient reports, she adds.

It's crucial, Wolin says, to determine a "downtime system" for when the electronic forms system is not in operation for any reason. "It's important to have the ability to do off-line documents, so you can go to the terminal and print documents without the patient's name, as if they came from your forms vendor." That could mean either generating blank forms and adding labels to them, or simply keeping a single form on hand that can be taken to the copy machine, she says.

"The next piece is how you decide whether a new form is going to go on-line," Wolin says. "What we've defined is that when there is a need for a new form, [the request] goes through a documentation committee, then to the medical records committee, and then to the forms committee, which determines whether to put the form on-line, to send it to the print shop, or to get it from the forms vendor."

The criteria used are the quantity needed, who uses the form, and the benefit of having it on-line as opposed to in hard copy, she notes. "It may be a form used only by case managers for tracking or one used only by the telemetry unit. It may not meet normal size dimensions, such as a full four-page foldout."

Then, Wolin adds, the appropriate question may be, "Is there a reason it needs to be a fold-out?" One side benefit of installing the electronic forms system, she points out, is that it offers an opportunity to revisit the design of forms that have been around for awhile.

"Our physician orders are on multi-ply forms, and they take the second page and fax it to the pharmacy," she says. "If you fax it, why do you need two copies? Why don't you just fax the first page and put the original back in the chart? Those are the things you go through."

A nurse pointed out that she fills out the front of a form and then flips it over to answer a single question on the back, Wolin says. "We moved that question to the front of the page. It was just that when that form was originally designed, they ran out of room and had to go to the back. Normally, we're all so busy, no one will sit down and say, 'I wonder why this is like this,' and check it out."

Verdict still out on savings

Because Winthrop is in the middle of a major transition, it's not yet clear how much money the new system is saving, she notes. "We're destroying old forms, creating new ones, and stocking up on downtime forms. The [patient] floors have to order paper. Logically, there should be a cost saving, because plain paper is less costly than preprinted documents. Other hospitals have seen cost savings once [the system is] fully implemented."

Still, Wolin points out, the hospital also goes through many more printer cartridges, and more printers may be needed. However, legibility is dramatically improved because each copy of the form is a high-quality laser-printed original, she adds.

"It's hard to get your hands around what the cost saving is until you've tweaked the system," she says. "After the initial install, you look at the forms and say, 'Do you really need these forms? I thought I needed that fourth copy, but do I?'"

It's already clear that the new system is saving time and effort from a training perspective, Wolin says. Because forms print out in packets, depending on the type of patient being registered, it is far easier to make sure new registrars are in compliance, she adds. "Before, we had to say, 'For inpatients, pull these forms; for outpatients, pull these.' Now it's automatic."

However, employees have had to learn to change their registration routine, Wolin says, a process that becomes ingrained over time. "In the past, [registrars] would hand the patient a blank form. Now they have to wait for the form to print and give it to the patient.

"Before, when staff completed the registration, they would see the plate maker go off, and hear a 'dot-dot-dot' noise," she adds. "They were so conditioned to hearing that noise and then getting up to retrieve the form that at first people were reprinting forms. Now they have to get up even though it's silent. ■

HIPAA costs could quadruple Y2K bill

Hospitals could end up paying three to four times as much to comply with the Health Insurance Portability and Accountability Act (HIPAA) than they spent on the technology needed to prevent Y2K problems, according to a report by the international rating agency Fitch Inc. in New York City.

Analyst **Rebecca Lageman** said health care providers who don't assess properly and budget for HIPAA requirements "will place themselves at risk for possible financial peril."

Fitch estimates that most of the costs associated with HIPAA will be in modifying existing information technology systems or purchasing new ones, hiring and retraining staff, and changing existing processes for maintaining patient privacy.

Lageman said she believes the government's $5.8 billion cost estimate for HIPAA is a "far too conservative figure," adding that Fitch estimates the cost at more than $25 billion. The report is available at http://www.fitchratings.com. ■

Using the Internet for registration?

Hospital Access Management is looking for access departments that are considering letting patients become more actively involved in the registration process through use of the Internet. Some forward-thinking access professionals are suggesting that much of the process should be the patient's responsibility. We'd love to hear your thoughts and ideas on the subject for a future issue of *HAM*. Please send them to Lila Moore at (520) 299-8730 or lilamoore@mindspring.com. ■

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Editorial Questions

Call **Lee Landenberger** at (404) 262-5483.

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Are you ready to move? Opportunities abound

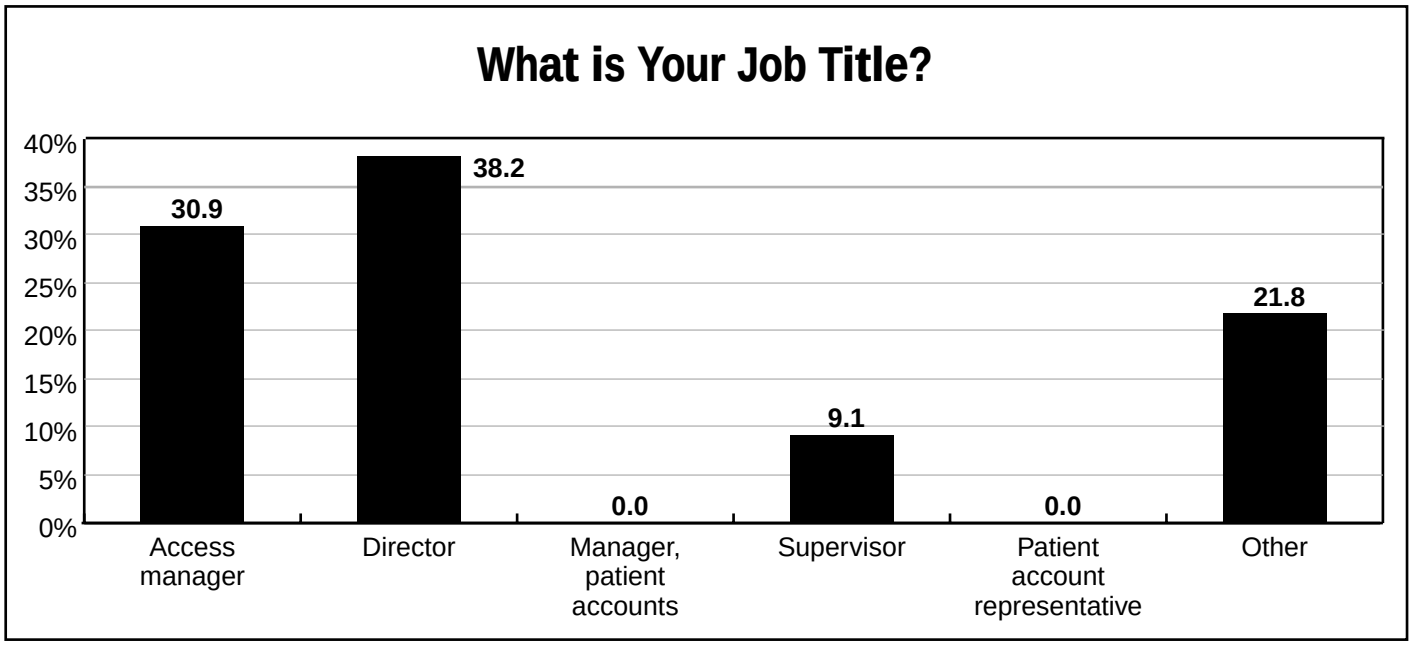
Salaries, job activity up, recruiters say

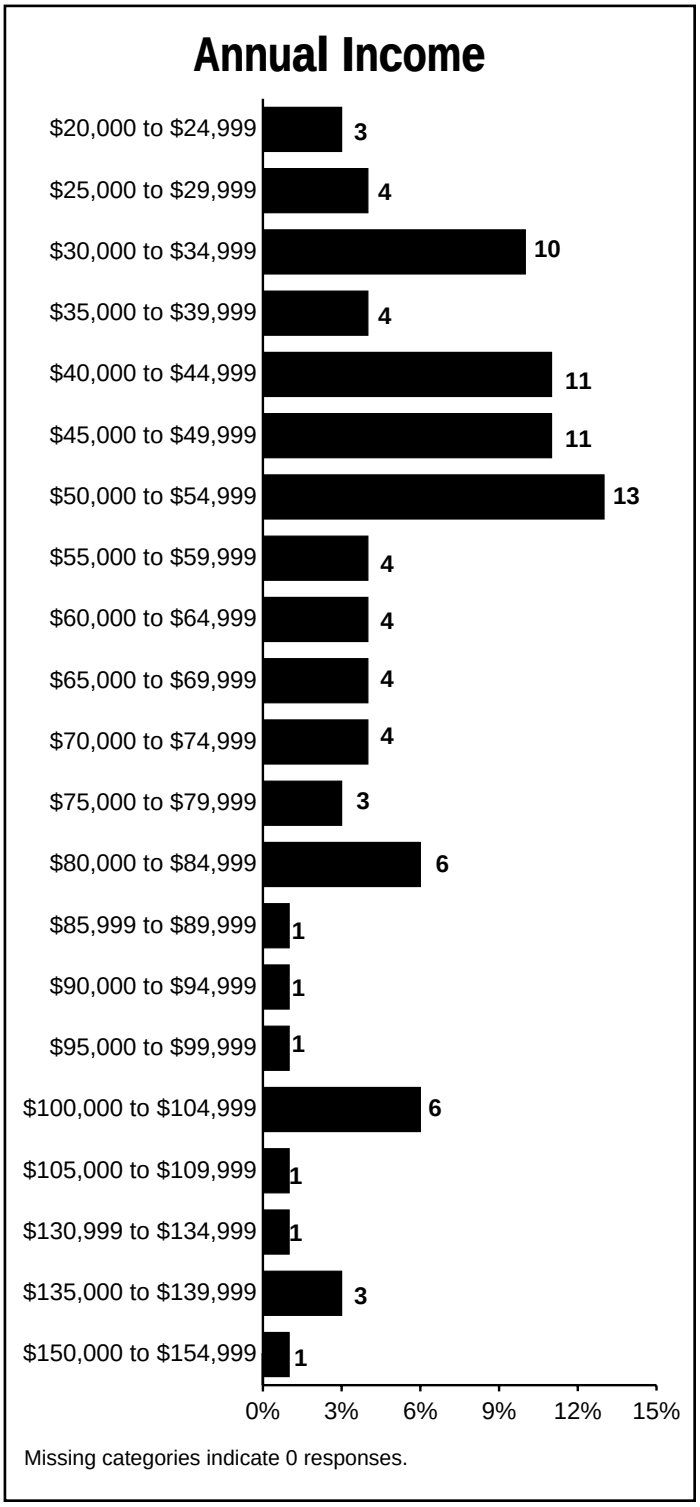
The job market for directors and managers of patient access services and patient financial services appears to be hotter than it has ever been. In some cases, hospitals that trimmed their staffs to the bone in response to the Balanced Budget Act (BBA) of 1997 have realized they can't do without the experience and expertise of qualified front-end managers.

Job placement professionals who talked with *Hospital Access Management* in connection with its annual salary survey report say opportunities abound for good candidates in the field, particularly those who are willing to relocate.

"The activity level has grown significantly," says **Doug Smith,** MBA, MHA, president of BE Smith Associates in Kansas City, MO. "The BBA thinned staff out, but some [hospitals] overtrimmed." Those facilities have discovered "they don't have a choice" but to have strong personnel overseeing the financial process, he adds. "They just didn't see the value before, and now they do."

There has been an accompanying jump in compensation, Smith suggests. "I have not seen





salaries escalate like I have in the past eight to 10 months," he says. "There is a labor shortage, and as hospitals bring in help, they are being more discriminating in who they bring in. They're doing much more thorough background checks and evaluations and only hiring the tops in the field. To get that, they're having to pay for it."

Smith estimates that salary levels have increased about 15% in recent months. "That's huge. [Financial] directors and managers have become very valuable in the marketplace and to the hospitals, which are trying to find every penny they can."

Hospitals are "beefing up the crew but still plan on running lean," Smith adds. "They're just bringing in the [work] horses."

Opportunities exist out there

Gina Seewald, a recruiter for Meridian Executive Search in Atlanta, agrees there are "by all means opportunities out there," with salary levels dependent to a large extent on geographical area. "It's a matter of whether or not someone wants to relocate," she says.

As examples of available salaries, Seewald mentions a position of director of patient financial services for a small psychiatric facility in New York that pays $85,000, and an admissions supervisor job in Atlanta for which the salary range is $38,000 to $45,000. The latter reports to the director of admissions, she adds.

Salaries for managers and directors of admissions, however, tend to be in the $40,000 to $60,000 range, recruiters told *HAM*, an estimate supported by responses to the salary survey. Some 70% of respondents to the survey said their title was director or manager of patient access. And although respondents reported salaries running the gamut from below $30,000 to as much as $150,000, the heaviest concentration was in the $40,000 to $55,000 range.

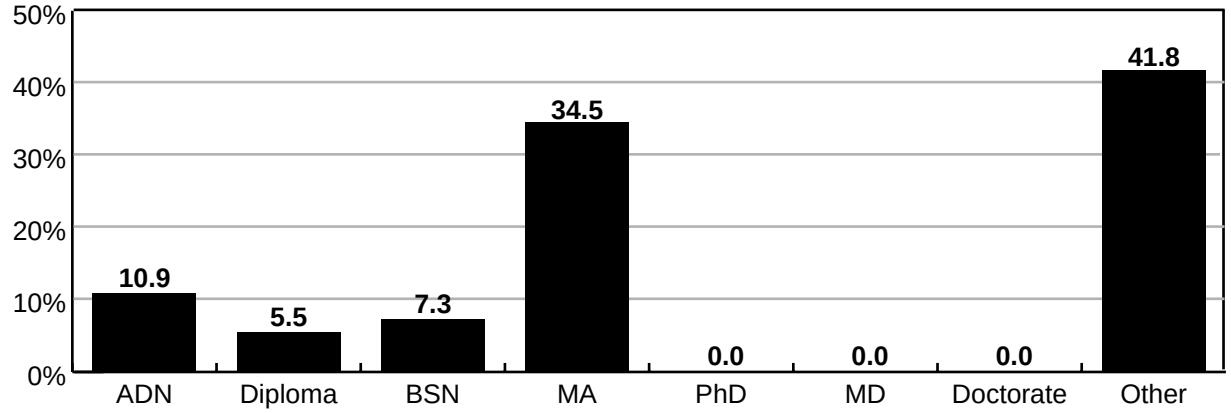
Some 25% of respondents said they had worked in the health care field for 25 or more years, and 65% of respondents said they had been in their current position for 10 years or more. Just under half of all respondents were between the ages of 40 and 50, and 34.5% said they had master's degrees.

A growing segment

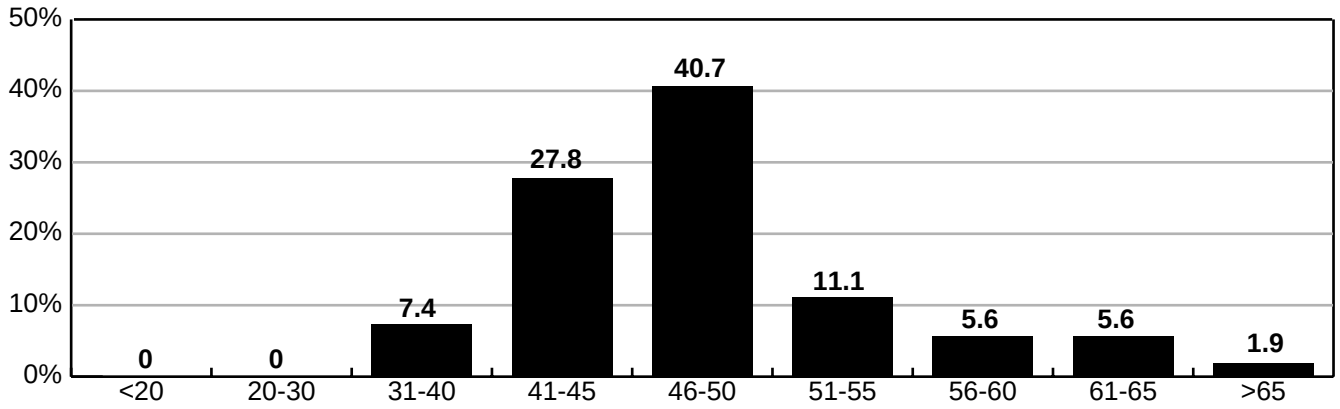
The 15% or so of survey respondents who said their salaries were between $80,000 and $150,000 are typical of what the recruiters say is a small but growing part of the access profession. Those people, who oversee access services for multihospital systems or supervise several departments within a single hospital, "are redefining the whole profession," Smith says. "I don't think the numbers are big yet, but that's where [the field] is going."

(Continued on page 4)

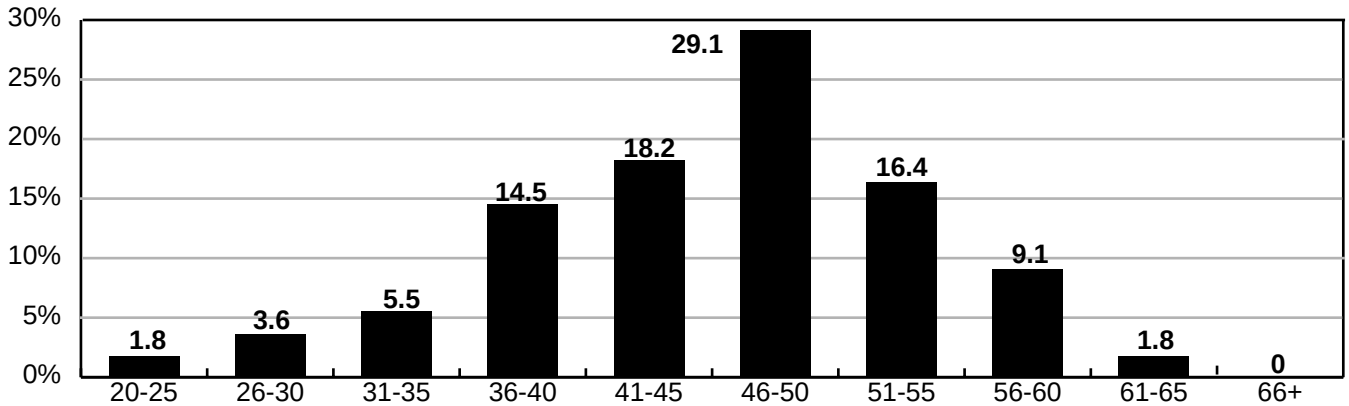
What is Your Highest Academic Degree?



How Many Hours Do You Work Each Week?



What is Your Age?



Hospital profit margins are so slim now, he adds, "that we will see a higher-level, more expensive, more highly regarded person managing those units."

Directors and managers of access or patient financial services who are looking to move up in the field would do well to gain experience in different kinds of institutions and with different types of computer systems, suggests **Roger D. Franck,** CHE, MHA, director of Cejka Healthcare Executive Search Services, which has offices in St. Louis and Atlanta.

> A recent phenomenon is the willingness of hospitals to pay top dollar for health care managers who will serve in an interim capacity.

"A couple of institutional jobs [is a plus], as is having multiple hospital oversight," says Franck, "not just being in one place for a long time."

"Now more than ever," adds Seewald, "there seems to be a need for a certain information system. The client will want the person to be information system savvy. There are a lot of conversions going on right now, so [experience with] multiple systems, different types of systems is needed."

A phenomenon Seewald has noticed recently is the increasing willingness of hospitals to pay top dollar for health care managers who will serve in an interim capacity. "What's interesting is that a hospital will pay just so much money [for a management salary], but will pay a great deal for a person who fills that position for three to six months," she says. Compensation for these interim directors or managers can include full expenses, a weekly flight home, and an hourly rate of $100, she notes.

Although Seewald has seen more examples of this arrangement with professionals who have a patient accounting or hospital information systems background, she believes qualified access managers can become part of that trend. "There seem to be more and more [consulting opportunities] due to the fact that an organization needs someone immediately while searching for a full-time [employee]"

Access managers and directors who have strong financial backgrounds also might want to expand their potential job searches to freestanding medical group practices, Franck suggests.

These large clinics, with as many as 300 physicians, are more prevalent on the country's East and West coasts but also are found in other areas, he notes. Minnesota, for example, is "group friendly," Franck adds, while St. Louis "does not really have that mentality.

"For patient financial services people and directors of patient access services, these are great alternatives," he says. "They are outpatient-focused, with multiple access points. The challenge there will be scheduling problems, and clinics and physician groups at different sites having their computers talk to each other." ■