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INSIDE

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With pro-patient legislative climate, regulations likely to get tougher

HCFA inspectors can be subjective, experts warn

[Editor's note: This is the second article in a two-part series on recent revisions to the Health Care Financing Administration's (HCFA) interpretive guidelines for the Emergency Medical Treatment and Active Labor Act (EMTALA). Last month's article looked at the tightened definition of "medical screening exam" and why triage doesn't qualify. The EMTALA statute, regulations, and site review guidelines can be accessed at the following Web site: http://www.medlaw.com.]

One thing seems clear: The law protecting patients' rights to emergency treatment is here to stay. Even if EMTALA were to be revised, chances are it would be made even more stringent, says **Stephen Frew**, JD, a Rockford, IL-based health care attorney and consultant. "In this climate of concern about patient protection, it would be almost impossible to get EMTALA amended, except to make it even tougher," he predicts. "No legislator would loosen patient protections that already exist."

HCFA's EMTALA task force, which has contributed input on a regular basis during the two-year process of revising the guidelines, is not scheduled to meet again. "It's not clear if they will reconstitute the task force; however, it's anticipated that there will be some mechanisms to continue the dialogue," says **Charlotte Yeh,** MD, FACEP, chief of emergency medicine at New England Medical Center in Boston and a task force member. "We hope that the discussion will continue on an ongoing informal basis."

Still, the new guidelines won't be the last chapter in the book on EMTALA. "This isn't the end of the issue," says Frew. "My understanding is that HCFA will be sending out clarification letters defining issues such as the difference between a patient being stable, as

The Results Are In

In a special report on our 1998 salary survey **(see insert)**, *Hospital Access Management* explores the patient access director's ascent up the corporate ladder. It's not happening everywhere, but cutting-edge organizations are catching on, say specialists in finding jobs for health care professionals.

opposed to stable for transport."

The more clarifications that are added to the site review guidelines, the more likely EMTALA will be applied uniformly, he says. "But the fact remains that just like traffic cops, HCFA inspectors can be subjective. They all have prosecutorial discretion. They may choose to nail one [institution] for an offense and let another by because they have a higher level of confidence in that institution."

Emergency department (ED) access managers need to be familiar with the actual EMTALA regulations in addition to the new guidelines, urges Yeh. "The guidelines do not change the law. They are just how HCFA will choose to interpret the statute," she says. "Ultimately, the key to compliance is really to assure that patients, whether in the ED or elsewhere, are treated in a nondiscriminatory fashion."

Experts suggest examining the following areas where the new guidelines might require a revision in policy or procedure:

1. **Transfer from a hospital after admission.** "The guidelines do not address the scenario of a patient being admitted to a hospital and transferred to another facility days or weeks later," notes **Larry Bedard,** MD, FACEP, director of emergency services at Doctor's Medical Center's San Pablo and Pinole (CA) campuses and immediate past president of the American College of Emergency Physicians (ACEP).

One patient who was transferred after being admitted has pressed an EMTALA investigation that will be the first to go to the Supreme Court, Bedard says. "This is an important issue," he explains. "The day the patient was transferred to a rehab hospital, she required admission to another acute care hospital. She went from acute care to extended care, [then back] to acute care, claiming the first hospital should have kept her there."

The particular case, *Roberts v. Galen of Virginia, Inc.*, hinges on whether the violation occurred because of monetary gain, Frew says. "If they confine it to the issues of the case, it won't affect the general climate of EMTALA. But it will be the court's first chance to comment on the law at all, which will be interesting."

2. **No discussion of finances.** "To be completely safe, you can't have any financial discussion whatsoever with a patient," says Bedard. "If an HMO patient came in and said, 'My HMO won't do a back X-ray but I want one, how much will it cost me?' you can't tell them. The attitude that you can't tell the patient what the cost will be or imply that they won't have any responsibility for payment is absurd."

The policy of never discussing finances violates consumer rights, he says. "I don't think there is any service in this society where you don't have a right to ask for the cost," he argues. "I call this the HCFA gag rule."

3. **Signage issues.** The guidelines do not address what sign, if any, is permissible to post in the ED regarding patient responsibility for payment. "They can charge you with coercion if the patient leaves because you told them the bill would be expensive," Bedard says. "That could include posting a sign that says if insurance doesn't pay, we'll send you the bill."

More than half of the hospitals in the country have similar signs posted, he notes. "They could be interpreted as a form of coercion. If that's the case, HCFA has an obligation to notify two-thirds of the hospitals in the country that they are in violation of the law."

4. **Dual staffing.** There is a trend toward MCOs placing their own physicians in a hospital's ED but only to provide treatment for patients who are plan members.

In Denver, Cleveland, and the state of North Carolina, Kaiser Permanente has closed its own facilities and signed a contract with a non-Kaiser facility for ED physicians to selectively see the HMO's patients, Bedard reports. "Kaiser is aggressively moving forward with this option in California," he says. "This raises a tremendous number of issues with EMTALA."

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The California chapter of ACEP has requested a ruling from HCFA on the legality of this arrangement, Bedard reports. "We will be seeing this situation more and more in this managed care environment," he says. "HMOs want to put their own physicians in the ED to see their own patients. But if you try and segregate them out, we think that violates EMTALA."

5. **Psychiatric patients.**

"There needs to be a lot more education about psychiatric patients, because there continues to be a lot of confusion and variation in standards of practice," Yeh says. "People tend to think that a psychiatric screening exam is not required. But it's very clear that these patients must have a full screening exam, both medical and psychiatric." ■

Revised guidelines shed light on confusing cases

Hospitals get timely advice on avoiding risk

Several aspects of the Health Care Financing Administration's (HCFA) new interpretive guidelines for enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA) hit particularly close to home, says **Cynthia A. Frizelle**, RN, BS, assistant director of admissions / registration at UCSF Stanford Healthcare in San Francisco.

A seminar sponsored by the Sacramento-based California Healthcare Association (CHA) provided insights on handling recent patient cases at her organization, as well as timely advice on avoiding potential violations, says Frizelle, who recently moved to her position at Stanford from the UCLA Medical Center in Los Angeles.

One guideline revision states that the lack of an established emergency department (ED) does not mean emergency services aren't provided, she points out. It defines the ED as any hospital service that provides emergency services, which is important from an access standpoint, she says.

"That could include labor and delivery or psychiatric [facilities]. Along the same line, if a patient needing emergency care comes to a treatment site that is contiguous to where the hospital's ED sits, staff in that area must perform a medical screening exam *within* that site," she notes. "That really puts any area on the hospital campus at risk. A parking lot structure, if on campus, could be subject to following EMTALA guidelines, so that a medical screening exam must be done.

"If a patient comes to, say, an urgent care setting or a clinic and says, 'I need emergency service for severe pain,' whether or not that person has a scheduled appointment, the clinic staff must perform a medical screening even if the patient does not have sponsorship (insurance coverage)," Frizelle adds. "They can't [according to the guidelines] send the patient to the ED to be evaluated, which is usually what happens if they don't have sponsorship."

It is illegal to ask patients for a co-payment or for any type of financial information, even if patients offer to call their HMOs.

Off-campus clinics billing under the hospital's Medicare provider number are considered part of the hospital, and must comply with EMTALA, according to the revisions.

It is illegal to ask patients for a co-payment or for any type of financial information, she notes, even if patients offer to call their HMOs. "You can only get enough information to start a medical record." The key is that all patients with the same medical condition be treated in the same way, she says. "You can only move a patient if there is a bona fide medical reason to move the patient, or if all patients are handled the same way."

The new interpretive guidelines also specify that a patient presenting at any part of a health care organization — whether it be ED, off-site clinic, or another site — asking for emergency care must have his or her name entered in a central log for the entire organization, Frizelle says. Each area may have its own log, but the names eventually must be combined in the central log, which must be available to a HCFA surveyor in a timely manner.

A potential risk situation that UCSF Stanford Healthcare is clarifying, she says, involves the handling of self-pay ED patients. "We have financial counselors who go into the ED setting and

help patients there," Frizelle explains. "Many times, the clinical staff just tell us there's a self-pay account in room three. The patient must be cleared [by a medical screening exam] before we go in and start talking about finances, so we have to make sure everyone involved is educated about the process."

As part of its employee education efforts in this area, UCSF Stanford recently developed a "Code of Conduct and Principles of Compliance," which covers EMTALA as well as other regulatory and ethical issues, she says. **(See related story, at right.)**

The EMTALA section of the code states that UCSF Stanford complies with all federal and state laws and regulations regarding evaluation, treatment, discharge, and transfer of patients with emergency medical conditions. It gives pertinent information about the required medical screening exam, emphasizing that triage is not considered to be a medical screening. It further states that a notice informing patients of their rights under EMTALA will be posted at all times in the organization's emergency departments.

Cloudy issues now in focus

Two cases Frizelle was involved with at a tertiary care center were clarified by the EMTALA consultant at the CHA seminar, she notes:

One case involved the transfer from another facility of a post-partum woman who needed a liver transplant. "MediCal wouldn't cover the cost of a transplant, but the other hospital agreed to paythe MediCal rate, to sponsor the patient, and we would take the patient and continue to try to get MediCal to cover it. After the fact, [the transferring facility] refused to pay us, saying we were violating COBRA."

Frizelle learned at the seminar, she says, that the receiving facility under no condition was obligated to take a patient from another inpatient facility, once the patient had been admitted to that facility. "We did take the patient anyway, and now the case is in litigation."

The other case had to do with another hospital's efforts to get the tertiary care center to take an inpatient who needed neurosurgery because of a subarachnoid hemorrhage, on the grounds that the first hospital did not perform neurosurgery, she says.

"HCFA's stand is, once the screening process is done [at the other facility] and they've admitted the patient, we don't have to do that." ■

Hospital's conduct code clarifies cloudy issues

Compliance one of several issues addressed

Compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA) is just one of the subjects addressed in UCSF Stanford Healthcare's new "Code of Conduct and Principles of Compliance," says **Cynthia A. Frizelle**, RN, BS, assistant director of admissions / registration.

The code of conduct, aimed at helping employees fulfill the organization's ethical and legal obligations to patients, was announced last August. It covers the following issues:

1. **Employee compliance (general)**:
This section addresses conflicts of interest, arrangements with vendors and third parties, and compliance with copyrights, patents, and trademarks.

It also deals with confidentiality of proprietary information, compliance with sexual harassment laws, and occupational and environmental safety regulations.

2. **Employee compliance (patient care)**:
EMTALA is addressed in this section, as are principles of patient care, patient information and confidentiality, medical records documentation, laboratory compliance, and home health agency compliance. Also discussed are billing regulations, including billing and coding compliance, patient co-payments and deductibles, and Medicare's 72-hour rule compliance.

3. **Business standards and compliance**:
Compliance with equal employment opportunity laws, compliance with the Americans with Disabilities Act, tax compliance, and antitrust compliance are addressed in this section. Also discussed are the prohibitions against payments for referrals, physician ownership in ancillary ventures, and document retention.

Employees who learn about a violation of the code are required to inform their supervisor, manager, or the chief compliance officer as soon as possible, Frizelle explains. They also may report violations by calling the organization's compliance hotline, in which case they may remain anonymous, she notes. ■

On-site training, auditing a success for registration

Long-time managers assume new role

Decentralizing registration while keeping staffing costs and error rates under control has been an ongoing challenge at health care organizations across the country. For the Franciscan Hospitals of Ohio Valley in Cincinnati, the mix is working, says **Patricia J. Young**, CHAM, regional registration process manager.

Franciscan's success, she explains, has come with the virtual disintegration of the patient registration department and the assumption of registration duties by other areas. The key has been Young's transformation — along with her counterpart at the hospital's other campus — from traditional department manager to a kind of floating monitor of registration accuracy and efficiency.

"Our main focus in the whole process was to increase customer service for the patient and the physician," she says. "We felt we needed to develop a method for the patient to go straight to the [clinical] department and get registered so tests could be ordered on the computer and they could have the tests."

The idea was to replace the "get up, sit down, get up, sit down" routine of traditional registration, Young adds. With that in mind, the hospital decentralized its registration procedures, she says. Patients were sent to the point of service, where a "quick and dirty" registration was performed by the technician or clerical person in that department. "They did just enough to allow them to get a number to order the test," Young explains. These quick registrations, which included basic demographic information and a copy of the patient's insurance card, were then sent to the billing department for completion.

Unfortunately, she adds, the employees doing the quick registrations, although highly skilled in clinical duties, were not attuned to insurance regulations and compliance issues. "We found we were jeopardizing the billing process. In this age of insurance, nobody knows what [coverage] they have, and what they have changes from day to day. When the patient asked questions, the [technicians] didn't know the answer. They could tell them if there was a problem with their blood, but nothing about the registration or insurance arena."

At that point, Franciscan made the decision to decentralize what was left of the registration department — central scheduling and emergency department (ED) registration — and have those employees work for the managers in their areas. **(See related story, p. 138.)**

Instead of reporting to Young, the ED registrars would report to the nursing department through the ED manager, and the central scheduling employees to the surgery department. That freed Young, who works at Franciscan's Western Hills campus, and her fellow registration manager at the Mount Airy campus, to begin close monitoring of registration in the ancillary departments. Using an Excel worksheet to track errors, Young oversees registration activity wherever it is done, she says. "We also do a page of these employees' evaluations, so instead of being based just on clinical performance, they're also based in part on clerical."

During her registration audits, she has found a series of simple but crucial errors. "We found things like not witnessing [the signing of] Medicare questionnaires with a full name, which is a requirement. These are just little things, but things that could cause a bad audit from Medicare and lead to a full investigation, which is something nobody wants." These "little things," Young adds, were those she had no time to do while managing a registration department with 21 full-time-equivalent positions.

Billing workshops successful

"We have found that training is the key, no matter what, no matter who the employees are," she emphasizes. "It must be ongoing training, because insurance companies are changing, rules are changing."

Young and her counterpart at the Mount Airy campus work closely with the hospital's managed care department to keep the lines of communication open. "Sometimes [registrars] don't realize that contracts with managed care companies require us to do something that we think the patient should do," she adds. "It might be that for a certain procedure we have to call and make sure there is a referral because of the way the contract is written. We might assume the patient has done that."

In another effort to improve communication between departments, the hospital recently held an all-day workshop for the billing department. "There was a lot that the billers completing these quick registrations didn't know," she points out. "Nobody had told them, for example, that for a

quick registration, the [departmental technician or clerk] only put down limited information and then copied the insurance card."

The idea was that billers would complete the registration, building on those data. But when billers saw that certain insurance information was not in the computer, they would throw the bill back to the department involved, Young says. "At the workshop, we let them pretend they were the registrars in these departments. They were saying, 'Oh, I see why [registrars] don't see that. They only see three screens, and there are 18 in a full registration.'"

The ongoing difficulty in a decentralized registration environment, she stresses, is keeping staff up to speed on what they need to know. The process is complicated by the large number of people in departments with a great deal of turnover, she adds. "For people in these departments, their job is often a steppingstone to some other clinical position. In registration, it tends to be a career job."

The addition of the registration process managers has helped this situation tremendously, she notes. Now, even though these registrars are disseminated throughout the organization and report to different managers, they can look to Young and her Mount Airy colleague for education. "Even the clinical people are more comfortable with doing registration because they know they can call us. Before, they went to their manager, who said, 'I don't know anything about registration.'"

Even with these improvements in place, Franciscan is looking at another option that would further alleviate the training dilemma, she says. The hospital is considering establishing a call center, which could meet the organization's customer service and accuracy goals in a more organized way.

"The patient would go to the point of service and would pick up a phone and give registration information to [a representative in] the call center," she explains. "We would have [the call center staff] every day to train and update, instead of training somebody in a clinical department for two months and then they're gone." ■

Need More Information?

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Jobs shifted, not cut, in on-site switch

When Franciscan Hospitals of Ohio Valley in Cincinnati decentralized registration, eliminating the traditional admitting department and reducing registration full-time-equivalent (FTE) positions, it did so without laying off any employees, notes **Patricia J. Young**, CHAM, regional registration process manager for the Western Hills campus.

Before the reorganization, each of the Cincinnati campuses had a registration department with 21 FTEs reporting to a department manager, explains Young, who formerly held that position at Western Hills.

Now eight of those FTEs report to the emergency department (ED) manager at each campus. Four central scheduling FTEs now report to the surgery department at each campus. Six admitting coordinators still report to Young, and another six to her counterpart at Mount Airy campus.

'In a state of flux'

The registration process managers will relinquish responsibility for the admitting coordinators, she says, when a new patient accounting manager is hired. "They were to report to the patient accounting department, but that manager left, so the situation has been in a state of flux.

"There was some downsizing, but no one lost their job," she explains. When Franciscan Medical Center in Dayton (OH) merged with its Cincinnati counterparts, the billing operations for all three facilities moved to the Mount Airy campus. More employees were needed in that department, Young says, so some of the former registration employees moved to billing.

Admitting coordinator is a new position added as a result of the reorganization. Those six employees — four are scheduled each day — are called to the registration desk when a patient arrives for admission, Young says. They take the patient to his or her room and perform the registration, including insurance verification and preauthorization.

The admitting coordinators work 7 a.m. to 6:30 p.m. Monday through Saturday, she adds. After hours, the ED takes care of any admissions. "On Sundays, 90% of admissions are from the ED, so we don't need an admissions staff." ■

Staff get to live dream by axing the boss

Reorganization includes new education piece

When the patient registration manager at Memorial Hospital at Gulfport (MS) left her position this September, the hospital's chief financial officer (CFO) put an interesting proposition before the department's four team leaders.

"Rather than replace her, he asked if we would be a self-directed work team," says **Tammy Boudreaux,** team leader in patient registration.

The team leaders accepted the challenge while reorganizing their responsibilities within the department, which has about 75 staff. A fifth team leader will be hired, and Boudreaux has been designated to develop a program for training employees on the hospital's new computer system. After that, as compliance issues arise and regulations change, she will be responsible for their ongoing education, she says.

"Our hospital went through a reorganization a couple of years ago and was going to be team-directed," she explains. "Only a couple of units have really done it, so the CFO saw [the manager's departure] as an opportunity to continue with that." In addition to providing training and education, the work team's duties are as follows:

❑ **Two team leaders, one for the day shift and another at night, monitor the activities of patient access representatives.** The access reps perform registrations, including precertification and insurance verification. Boudreaux will continue to handle the day shift until a new team leader is hired.

❑ **One team leader serves as quality control coordinator, tracking the accuracy of patient access representatives' work.** This person also is responsible for training the information associates, employees who register patients at bedside. The information associates, formerly unit secretaries, handle only repeat admissions — patients already in the hospital's history file. In the case of new patients, they call an access representative, who comes to the patient's room to do the registration.

❑ **Another team leader oversees the financial piece of the patient registration department, supervising financial counselors and precertification specialists.** These employees follow up on registrations to make sure they are in compliance. If the access reps are unable to verify insurance or start precertification, these staff complete the process. The financial counselors also assist access reps in setting up payment arrangements that are outside the norm, and they help patients apply for financial assistance.

Although the various employee groups report to different team leaders, the work is not compartmentalized, but "just flows through," says Boudreax. "We're all responsible for the process, although each area has its own function."

Using the information compiled on errors and productivity, she provides performance feedback to all staff, including patient access representatives at Memorial's two urgent care centers and two off-site rehabilitation clinics. "They don't report to us, but we're responsible for their process. We're using [the new education role] as a learning tool to help identify problem areas." As team leader for daily access activities, she didn't have time to focus on correcting errors.

The department's standard error rate is 4%. Due to high turnover and other issues, it has been higher (5% or even 6%) at times during the past year, she says. Each month when the quality control leader reports the outcomes of quality tracking, Boudreaux meets one-on-one with employees whose work falls below the 4% standard. "With those who don't reach that, we try to find the problem area, and the employee may have to go through retraining. Just with what we've already put in place, [the error rate] has dropped to 3% in the past month. We want it even lower."

Dividing the duties

Meanwhile, the new self-directed team has been faced with splitting the duties formerly handled by the department manager, Boudreaux points out. "We've had to decide who will do the interviewing, who will give the information to human resources, who will do the payroll, who will do the budget." Participation in the manager's various committees and meetings also has been divided among team members.

Team leaders meet weekly at a set time no matter what else is going on, she says. "That's when we can finally talk, learn what's going on for the

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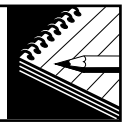
week, learn each other's schedules. If one of us needs a pep talk, that's when that happens."

When the fifth team leader is hired, the team plans to set aside a day to develop a mission statement and goals for the department, she says.

"Before this, we were team leaders who reported to a manager," she notes. "Now we report to each other, and we will do each other's evaluations. Mine is due first." ■

GUEST COLUMN



Health system takes aim at duplicate numbers

By **Lynne Gentry**, Registration Supervisor
MultiCare Health System
Tacoma, WA

In February 1996, MultiCare Health System in Tacoma, WA, began to address the problem of duplicate medical record numbers in the hospital information system.

About 150,000 of 787,000 medical record numbers in the master patient index (MPI) were identified as possible duplicate medical record numbers. An MPI conversion to a new hospital information system in 1993 and the decentralization of the admitting department in 1994 contributed to the increase in duplicate medical record numbers.

Not only were the registration responsibilities added to the unit secretary's duties, but the birth of Washington state's managed care Medicaid program also occurred in 1994. An ever-increasing number of managed care insurance plans added to the complication of the registration function now performed on the nursing units.

MultiCare Health System includes a medical center comprising two acute care hospitals totaling 388 beds, 34 outpatient clinics, 17 lab sites, and two day surgery centers for adults and children.

The health system also includes a third, off-campus, 66-bed hospital, 42 physician offices, six clinics, eight urgent care centers, and a physician residency family practice center. The hospital information system is used by the medical center and by the third hospital.

The project mission was to "design a process to establish and maintain the integrity of the medical record numbering system." MultiCare used a multidisciplinary approach to tackle this issue. The first phase of the project was to create a manageable set of recommendations that would solve the problem. The second phase would be to implement those recommendations.

An operations improvement team consisting of representatives from nursing administration, patient financial services, lab, radiology, patient registration, the emergency departments, health information management, information services (IS), and operations improvement made up the recommendation and implementation teams. Some representatives were asked to participate in both phases.

The recommendation team met eight times from February through May of 1996 and made the following recommendations:

- Create administrative policies and procedures.
- Create a communication strategy for referral sources to include a basic registration form with standardized and required critical data elements. Additional information to meet the needs of a specific department also could be included.
- Provide education to minimize duplication of medical record numbers.
- Create accountabilities.
- Create a standardized quality assurance procedure for registration.
- Provide "cheat sheets" at each registration area.

Team determined policy and procedure

The implementation team first met in June 1996. It was divided into subgroups to address five of the recommendations. The entire team addressed the development of the administrative policy and procedure that would be followed by the medical center. The team met every two weeks for five months; the subgroups met regularly based on the entire team's critique of project status.

The policy and procedure proposal was ready for administrative committee approval in November 1996 and became effective that December. The team created a referral source communication and registration data verification checklist, which was laminated and placed at all unit secretary stations. The team also developed a competency checklist.

The IS department began the task of the automatic merge of those duplicate numbers that met specific matching criteria. The education plan and quality monitoring plan also were approved. Written documentation was disbursed to 178 supervisors, managers, and directors, informing them of the expectations and accountabilities of the new process.

Before those performing registrations could be held accountable, there had to be an education mechanism to give them tools to reduce the creation of duplicate medical record numbers. The team's education subgroup, led by a clinician from MultiCare's center for clinical education, developed a computerized slide presentation, classes, and a video to be used in educating those who had registration responsibilities. The video was made using members of the task force portraying various registration scenarios.

Education now available

The education program is ongoing and available to new hires and existing staff who need further assistance. It was presented by our clinical nurse educator at Rutgers State University's 16th Annual Nursing, Computer and Technology Conference, held recently in Orlando, FL.

A senior applications analyst from the IS department identified 77,000 duplicate numbers that were eligible for the automatic merge process, which occurs at the database level. This process began in December 1996. The 1997 target for the number of records to be merged was 31,000.

By November 1997, the actual number of duplicates merged had reached 56,221. Included in the merge process was the actual consolidation of the medical record charts by the hospital information management (HIM) department based on reports of merged records provided by IS. Those reports also were provided to ancillary departments to merge patient records manually in their clinical information systems.

By May 1998, a total of 75,752 records had been merged through this automatic process, and the second phase of the cleanup began. This phase includes the provision of additional reports to HIM, which lists those MPI records that may be duplicates, based on patient name and date of birth. HIM reviews information on the hospital information system and the actual medical record chart. If a merge is required, HIM completes the system and chart merge.

The plan for quality assurance involved a coordinated effort among IS, HIM, the quality registration department, and the center for clinical education. IS generates a daily report on the duplicate numbers created the previous day. Monitored by the quality registration department, the report lists the duplicates created, who created them, and on what day.

Statistics on system users who may need more education are maintained and distributed to directors. (This monitoring procedure also identified a common function employed by system users that prevented them from looking for established medical record numbers.)

For those who occasionally create a duplicate number, a reminder notice is sent containing techniques that will help deter the creation of duplicate numbers. Information is then relayed to HIM on those numbers that need to be merged in the hospital information system. A physical chart merge is performed after the patient information has been confirmed. Information is relayed to the registration and operations improvement departments for statistical purposes.

Without intervention, it was projected that duplications would have continued to escalate, possibly reaching 5,000 additional duplicate medical record numbers per year. The actual figures demonstrate a reduction in duplicate medical record numbers to an average of 27 per month in 1997 (out of an average of 23,268 new registrations created each month).

For the current year, January through June 1998, an average of 33 duplicate numbers have been created (out of an average of 27,084 new registrations per month) while operating at 100% capacity. More than 1,500 employees are authorized to perform registrations on the hospital information system and have the potential to create new patient records.

With that in mind, the duplicates created are remarkably few in number, especially considering that the registration functions are performed by multi-skilled staff at the point of service in an ever increasing managed care environment. ■

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Here's your chance to speak your mind

Some say salaries don't match job demands

Due to the demands of managed care, the front-line access employees of today bear little resemblance to the clerk-typists of the past. With billing and coding duties shifting to the front end and emphasis on generating a "clean claim," these positions have become more technical and more crucial to a health care organization's success.

In many cases, however, salaries have not increased accordingly, notes **Liz Kehrer,** CHAM, patient access manager at Centegra Health System, McHenry, IL. "What may be a trend," Kehrer says, "is the shifting of patient accounting responsibility to the front without pay being adjusted."

Survey examines frontline pay

With that mind, Kehrer has designed a survey to look at how frontline access employees are paid at health care institutions across the country. "Are they being compensated adequately, considering what they're expected to do?" she asks. "They're the ones who take the brunt of customers' frustration if the emergency department is backed up and there's a two-hour wait or if pre-certification calls during outpatient/inpatient registration take half an hour."

To participate in Kehrer's survey, complete the enclosed form and return it to: *Hospital Access Management* Reader Survey, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Or fax your survey: (404) 262-5447. Results will be published in a future issue of *Hospital Access Management.* **(For other salary information, see our 1998 reader salary survey report, also enclosed in this issue.)** ■

Technology, touch create new model of health care

From sickness center to healing center

Would your facility be mistaken for a resort? Given the unassuming — and often unappealing — design of most traditional hospitals, it's not likely. But at Celebration Health, a 315,000-square-foot health care center located just south of Orlando, FL, travelers often are attracted by the 1930s Mediterranean style architecture, complete with octagonal tower, says **Des D. Cummings Jr.**, PhD, CEO of the development division of Florida Hospital.

"They think we're a resort. So they ask about rates or try to check in," he says.

The confusion is understandable. From the approach over the causeway to the light-filled atrium, the 60-bed facility looks like anything but a hospital. Patients and visitors enter the campus via a causeway lined with palm trees. The 65-acre campus, carpeted with Kentucky blue grass, is surrounded by a lake. "The environment outside sets the tone for the healing that takes place inside," Cummings says.

In the building, the hotel-like lobby also is bathed in light, he adds. A sunlit atrium with flowers and greenery replaces the fluorescent lights and mazes of corridors typically found in hospitals.

Applying the 'front-stage concept'

The resort illusion continues because designers used what is called a "front-stage concept."

"You won't see any patients being wheeled on gurneys because we transport them through the back corridors. It not only gives them privacy, but it allows those who come for wellness programs or other services to have a soothing experience," he says.

For example, in addition to traditional primary care and specialist services, Celebration Health boasts such amenities as a world-class vegetarian restaurant and fitness center with a day spa featuring massage therapy, herbal wraps, and facials.

"Celebration was built on the belief that the hospital of the future should be a facility for the whole person for his or her whole life — not just during sickness or surgery," Cummings says.

By providing a healing center for all phases of life, rather than a hospital for episodic times of illness, Florida Hospital, a 1,452-bed system on six campuses, hopes Celebration Health will serve as a prototype for the future of health care.

"Our No. 1 purpose is to help people see they are their own primary care givers. By the way they live their life, they are primary determiner of their health," Cummings says.

During an MRI, patients can watch a movie through a viewer installed inside the equipment. For children, this treat can reduce the trauma, pain, and cost of the procedure.

To this end, Celebration includes, but moves beyond, the traditional inpatient and outpatient services of the health care setting. In addition to the physician office building that houses more than 70 primary care doctors and specialists, the facility includes a "Lifestyle Management Center" that empowers positive changes by addressing emotional and spiritual needs rather than just physical ones.

"If we're going to make Americans truly health-oriented, we need to change their views of the hospital from a sickness center to a healing center," Cummings says.

Technology enhances patient care

But Celebration isn't just an intangible, warm and fuzzy concept. It's one of the most technologically advanced facilities in the world, says Cummings. More than 25 companies such as General Electric, IBM, Pfizer, Sprint, Hewlett-Packard, Johnson and Johnson, and GlaxoWellcome have formed strategic partnerships with Celebration.

"We knew that if we were going to launch the health culture of the 21st century, we couldn't do it by ourselves," Cummings explains. "So to create a model organization, we included partners who share the vision."

Crucial to the concept is that such state-of-the-art technology exists to "provide modern medicine with an old-fashioned touch," he says. "The basis of healing is the personal relationship between the patient and the caregiver. Technology should never intrude into that relationship."

For example, computers are located right outside the patient rooms and not by the bedside. "You don't want the technology between the caregiver and the patient," he says. "Neither do you want it to detract from the healing environment."

By configuring inpatient areas to the "universal room" concept, technology can be added or removed according to the patient's needs, he adds. "Every room is certified for intensive care, med-surg, and rehab. If needed, the equipment slides out easily from behind a panel of armoires. That way, the room is transformed into the appropriate level of care and the patient never has to leave," he says.

Harshness is minimized

Even in technology-intensive areas like the radiology department, the harshness of technology can be minimized. "Instead of looking up at the usual fluorescent lights and ceiling tiles, we have created healing pictures of illuminated nature photographs: lakes, trees, oceans," Cummings says.

And during an MRI, patients can watch a movie through a viewer installed inside the equipment. For children, this treat can not only reduce the trauma and pain of the procedure but also the cost. "Instead of having to be poked with an IV and sedated, many children are able to undergo the procedure without it," he says.

Such a "soft-technology" approach should exist to "keep documents and information, but people keep the relationship," he adds. For example, to enhance the speed and accuracy of pharmaceutical services, physicians transmit prescriptions electronically. "This also frees up more time for pharmacists to have consultations with patients," Cummings says.

The same goes for the digitized technology at the imaging center. "In traditional settings, the radiology technician takes the images and then goes away for about 10 minutes to develop the film," he explains. "In our setting, he or she can stay right beside the patient because the image takes about 30 seconds to appear on the screen."

In addition to increasing caregiver time with the patient, this instant imaging means an increase in quality. "There are fewer retakes; the tech can change the shadings immediately if needed. He or she can also print out a copy for the patient," he says.

The facility's technology is evident the moment one walks through the front door — and even before. For example, a centralized scheduling system for all six Florida Hospital campuses allows patients to make appointments for physicians and procedures with just one phone call.

Patients who aren't pre-registered — about 30% — have to supply information only once, thanks to the paperless medical record system.

The majority, who are pre-registered, go directly to individual registration areas, where attendants greet and provide them with pagers if the visit requires a wait, Cummings says.

"They are free to move around building until the appointment," he says. "With the pager, they can go check their children into the play area, visit the library, or the restaurant." (Child care costs about $2 per hour.)

Computer stations provided

They also may use computer hookups or phones to make conference calls or work on their laptops. For those who want to learn more about their health concerns or those of their loved one, there are computer stations with touch-screen monitors in the lobby and other areas throughout the facility. "They can research health information, take health surveys, access Web sites," Cummings says.

For example, Health Compass is an Internet-based service that establishes a single place where patients can maintain, receive, and distribute personal health information about themselves and their families in an easy-to-use secure system.

Yet many patients still have to be encouraged to take advantage of these features. "They are so conditioned to waiting, so accustomed to thinking of the doctor's time as being sacred that they have a difficult time imagining there is another way to do this," Cummings says. ■

Send us your thoughts

Do you have an access management success story? If so, we'd love to hear from you. Contact Lila Moore, editor of *Hospital Access Management,* at (404) 636-9264. Or send an e-mail message to lilamoore@mindspring.com. ■

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