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INSIDE

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Should the standardization engine be slowed when hospitals merge?

Gutting your operations isn't always the best way, experts say

When hospital mergers occur, it seems normal to crank up the standardization engine as soon as possible. Management then works furiously to eliminate different ways of doing things at the various facilities and to achieve uniformity in everything from forms to dress codes.

"Is there another way to go?" asks **Beth Ingram**, CHAM, systems consultant for Superior Consultant Company in New Orleans and a former access manager. "It appears there is some evidence that standardization may not always be the most cost-effective route.

"What I see happening in some of the mergers that have occurred is that millions of dollars are spent trying to make everything the same," she explains. "They want the same information systems, the same decision-support system, the same clinical system, so they can roll it all up at the corporate level." That means changing forms, changing processes, and changing policy and procedure, she points out. "Plus, there's the time lost while people get oriented to a new system that may not work for them in some cases."

> **"Think of the nightmare of auditing different forms, of running into those nightmares every day."**

In some large corporations, the financial impact of such a wholesale overhaul is significant enough that they haven't been successful, Ingram says. "There's no direct analogy, but the two things do seem to go together."An alternative, she says, is to consider reconciling disparate information coming from different places through the use of modern technology. "With all the decision support tools out there, the merger may be better served by pulling data together in a data warehouse as opposed to totally disrupting everything. You definitely want to go in and analyze, but I'm not sure ripping the guts out of an organization is the way to go."

Access managers and directors polled by *Hospital Access Management* about standardization expressed varying opinions based on their experience with multihospital mergers.

"Standardization is just part of the merger," says **Barbara Wegner**, CHAM, regional director for access services at Providence Health System in Portland, OR. "It was complete chaos, a real mess, and everybody is still trying to get it all standardized," says Wegner, who was involved in bringing together three hospitals and assorted ancillary facilities in a process that began five years ago. "We have struggled and struggled to get things standardized, but how you could function without [standardization] and be successful, I would not know."

Although she concedes that standardizing policies and procedures, consents, and releases at several facilities is an overwhelming and expensive task, she says not doing so would cost even more. "If you don't standardize all forms across the continuum, think of all the inventory in materials management. Think of the nightmare of auditing different forms, of running into those nightmares every day."

Still, exceptions to the standardization rule have been made, she says, when standardizing would upset the way a facility does business or cause a big operations problem. She cites one example that remains unresolved at her health system: "One of our facilities had a system whereby when outpatient day-surgery patients came in for a procedure, the computer did not show those patients as being in a bed. You could see [in the computer] that they were there, but they wouldn't be in a bed."

Another hospital's computer system, however, did show day-surgery patients in beds, Wegner says. "It caused problems for our cost-accounting system. It was impossible to figure out what kind of business we were doing, because we weren't counting them the same way."

Yet to make a change at either facility would cause a serious operations problem, she says, because of the accompanying nursing and documentation changes. Such a change would be particularly disruptive at the hospital where day-surgery patients were not shown to be in beds, she explains, because of the work that had to be done in putting a chart together.

"Going the other way didn't work for the other facility — where they do put patients 'in bed' — because the day-surgery, surgical prep, and ambulatory area are all in one place," she adds. "At the facility where they don't put day-surgery patients 'in bed,' those areas are in three different locations. We backed off that [problem] about three years ago, but we need to tackle it again. Our goal is to standardize as much as we possibly can."

Customers' needs can be different

There is another way to handle a merger, contends **Rita Borowski**, CHAM, patient access services director for Milwaukee-based Aurora Health Care's metro region. While some "easy hits" do exist for standardization, such as identification bracelets and service contracts resulting in immediate cost savings, Borowski says other things definitely should not be standardized.

"What you have to weigh is the cultures of the various facilities as they respond to their customer base," she says. "Even within our organization, there are rural, community, and urban settings. How facilities respond to customers and their needs can be very different."

Further, the different insurance types dominant in different settings play a role, Borowski adds. "What the major [insurance] players are may deem differences in procedures. At our urban site, we have 24-hour-a-day financial counseling coverage. At another site in the community, we have financial counseling during regular business hours. There's no reason to change that — it's distinctly relative to the customer base [the facility] serves."

On the other hand, standardizing dress codes at the facilities was the right thing to do for good customer service, she says. "We wanted all the customers of the Aurora organization to realize that no matter where they go, those in navy blue are the ones who can help them."

Borowski standardized job descriptions for access services personnel but rewrote them to be general enough for use among facilities. "What

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they perform within those job descriptions and titles varies across the sites."

Also, some departments use labels, while others use embossers for identifying items in the paper flow process, she adds. "It was working fine, so why change it? These are not things you should worry about. There's nothing to be gained by standardizing them."

There is a huge cost involved in bringing disparate facilities together, and it's likely to be a make-or-break factor for some organizations, notes **Charlene Overfield**, RN, CHAM, a consultant with Gustafson & Associates Inc. in Port Washington, WI. "It's not always healthy that each time you merge you have to come up with a new system," the former access manager says. "It has caused facilities problems when they've thrown out something that worked for them and replaced it with something that's hard to do. I've seen hospitals that really had to struggle."

But like Wegner, Overfield sees standardization as an inevitable part of the process. "It's expensive to do it, but there's no way of knowing if you're productive if there are different reporting mechanisms for different facilities."

And it's not just changing computer systems, she points out. Standardization also is being brought into a regional kind of philosophy: The blow can be softened, she suggests, if changes are made incrementally.

Overfield cites one hospital that, because of a merger, was slated to have its billing handled by a regional business office. "But once [management] came in, they changed the computer system but left the business office intact," she says. "They've taken it step by step, first looking at processes and then putting them on [the same computer system]. Down the way, they will be under a regional business office."

Similarly, that hospital's admitting department remains, for the time being, under the patient accounting director. Eventually it will be under a regional access manager, she adds. "Maybe it's best if you don't just go in and immediately change things. We've all been a customer of a merger, and for whatever reason, we think we'll lose the personal touch when a large system comes in and takes over a small one. That's another reason to take it slow."

Hospitals involved in a merger have reasons for wanting to remain different, Overfield says, while struggling to see how they compare with each other. Like Ingram, she sees the feasibility of a common reporting mechanism that can make sense of disparate data. "If hospitals with different computer systems can feed raw data into [a decision-support system], they might be able to get out the same information." ■

Nurse screens orders *before* admission occurs

Patient, health system said to benefit

Screening admissions in advance for medical necessity is part of the routine at University Health System in San Antonio, thanks to an innovative utilization management program that appears to benefit both patient and hospital.

The effort began almost two years ago, when admissions and the emergency center (EC) were put under the supervision of **Betty Goularte**, RN, BSN, CPHQ, director of utilization management, admissions, and the EC.

"I began to see that, being a teaching and county hospital, we had a lot of patients that seemed to be walking through the front door to be admitted that didn't need to be admitted," she explains. "The admitting staff knew to call the physician's office if an admitting order was incomplete but were never really trained in conferring with the physician. No one ever stopped to say, 'Is this really an appropriate admission?'"

In other cases, physicians might not know there's an alternative to inpatient admission, or they may not have thought about it at all, she notes. "Their idea is just to take care of the patient."

Financial options offered when admissions flagged

When the admissions nurse at University Health System in San Antonio flags an admission request because of a problem with medical necessity, she has some financial options to offer the patient, says **Betty Goularte**, RN, BSN, CPHQ, director of utilization management, admissions, and the emergency center.

If a patient's admission doesn't meet medical necessity requirements, the physician is contacted to see if other alternatives can be explored, she says. That's the case no matter what the patient's funding source is, she notes, and if the physician insists on going through with the admission, "we'll ask for cash upfront."

Ideally, **Sandy Taylor**, RN, admission nurse coordinator, will work with the physician and patient to devise a care plan according to medical necessity, and if appropriate, get financial coverage.

"With nonfunded patients, we assess the diagnosis and plan of care and discuss it with the physician to see if it can be postponed until we find a funding source for this patient," Taylor explains. "We run them through the financial counselors to see if they qualify for Medicaid or for Carelink, a program that helps support the indigent in our county."

"If the patient is outside our county, and we can't help financially, we will give them phone numbers of resources in other counties," Goularte says.

"We try to be the patient's advocate," Taylor adds. "It's a benefit to the patient and the system that we put them in the proper status." ■

With stringent rules determining medical necessity and more procedures relegated to an outpatient setting, such an approach is not the best one for the patient or hospital, Goularte suggests. "A lot of times physicians feel they want to get the patient in and treated right now. That doesn't always work in the patient's best interest. When the physicians understand that [with nonurgent procedures] waiting a few days would help get [financial] coverage for the patient, they are usually very good at working with us." **(See related story, above.)**

Her solution was to formalize what had been an informal arrangement with utilization management (UM), she says. "We had been doing some liaison [work] with admitting, but it was cursory, just when we were called to send a nurse over to look at an admitting order. I decided to go for a full-court press."

A UM nurse was moved into the admissions department, where she works with the entire staff, particularly those employees overseeing admitting orders from physicians. The department uses admitting criteria that are part of published nursing guidelines to help determine the appropriateness of an admission.

Avoid 'red flag' situations

The idea was to be proactive instead of having UM pick things up retrospectively, when the patient was already in a hospital bed. It's considered a red flag, for example, when an order says the patient is going to have surgery, but there are a lot of diagnostic procedures to be done first, Goularte explains. "The surgery might or might not be done."

The UM nurse also would question an order for a patient to be admitted for incision and drainage. "That's primarily an outpatient procedure, depending on the condition of the patient. We have to know that outpatient therapy has failed. If it didn't work, that patient will get in the door."

Gall bladder removal is another procedure that was done in a hospital for years but now can be done laparoscopically on an outpatient basis, she notes. "Unless you know this, you don't know to call the physician. That's why it's easier to teach a nurse [to screen admitting orders] than an admitting person."

Goularte's own practice of calling physicians when she hears about questionable admissions predates her position as admissions department director, she adds. "The trail goes back several years. On the retrospective side, I was seeing Medicaid and Medicare patients getting in here who did not meet medical necessity."

Over the years, the medical necessity criteria have been expanded to include more and more patients. This past focus on medical necessity is one reason physicians are as cooperative as they are with the admission screening, Goularte suggests.

In rare instances, a physician might become defensive when an order is questioned, but it helps that a trained nurse is calling, she says. "And we don't just start by saying this is an inappropriate admission. We ask if there's any reason the physician is doing this as an inpatient rather than an outpatient procedure. Then we say, 'Can

we do it another way? I will help arrange it.'"

A UM nurse will never deny an admission, Goularte emphasizes, but she does have a backup if physicians refuse to discuss an admitting order. "There is a utilization review physician who is a consultant to me, and she can deny an admission. If I have someone who will not talk to me or the nurses, this person is called. She contracts with the hospital."

In most cases, adds **Sandy Taylor**, RN, the admission nurse coordinator, physicians are pleased when they understand that modifying an order would benefit the patient and facilitate appropriate billing for the hospital. "They want to take care of the patient," she says. "If we can handle the details, that's fine with them."

Some 10% of admitting orders are discussed with the physician, with the suggestion that the patient be handled in a different way, Taylor estimates.

"It's hard to get our hands around the money saved," Goularte says, "but we know that money is saved. We're trying to find a way to quantify it."

Effective education a must

The measure of the program's effectiveness may not come in numbers, however, but in the education it provides for physicians, Taylor suggests. "It's making them more aware that these issues need to be addressed, that they affect the patient."

If a Medicare patient is incorrectly put in "admit" rather than "observation" status, the patient will be responsible for paying the deductible for an inpatient stay, she points out. With commercial accounts, the admission request form shows that authorization was for an outpatient or observation patient, not for an inpatient stay.

"We're a teaching facility, and many residents and some attending physicians are not familiar with the details of payers," Taylor says. "Sometimes the clinic obtains the proper authorization, but when the order for admission is written, that order may need to be clarified." ■

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New department, manager push quality at St. Vincent

Effort includes mentoring, cross-training

As it grows by leaps and bounds, the patient intake department at St. Vincent Hospitals and Health Services in Indianapolis is making strides to ensure quality while managing at least 30 access points and more than 200 employees.

Comprehensive and consistent training for everyone who does registration is crucial to the process, says **Sue Underbrink**, hired in March 1998 as quality improvement and training manager. "We were in a decentralized environment for a few years, and now we're heading in a different direction," she says. "Even while doing that, we still have registration scattered out among different areas, and we're bringing smaller hospitals [into the health system]."

At present, she explains, preregistration is performed in the central patient access area. However, upon arrival at the hospital, the patient goes directly to the nursing unit where he or she will be an inpatient. Employees there finish the registration process.

"Eventually, in the next year or so, we will have centralized admitting again," Underbrink adds. "Patients will have been preregistered. When they come in, there will be someone on the first floor to hit the hot spots [of registration] and copy their insurance cards. Then someone will escort them to a room."

Like many health care organizations, St. Vincent has come full circle with the registration function. "In the late '80s and early '90s, there was traditional centralized admitting," she explains. "Then we went to patient-focused care, where registration was performed completely on the units. There were three or four years where the entire hospital was in patient-focused care, and then we started converting back."

There were good and bad aspects to the patient-focused care environment, Underbrink notes. "One of the problems with registration entirely on the units was that employees didn't do it enough to become efficient with all the variables. The same was true with the financial counselors and insurance verification [employees], who didn't report to a central department."

To ensure the accuracy and efficiency of St. Vincent's increasingly far-flung registration sites,

Underbrink is leading an ambitious training and quality improvement mission. Assisting her are two trainers and two auditors who assumed their positions in mid-October. Here are some components of St. Vincent's program:

1. **Intensive initial training.** Any new employee who will perform registration undergoes an intensive two-week training course. "This training is fairly general. We go through registration pathways and make sure they know the different insurance [types] and how to prioritize," she says. "They learn good customer service, telephone etiquette, how to probe to get information to complete registration — information they need for any registration area."

2. **On-the-job training.** The next step is to put new employees in the workplace under a "buddy" or "mentor" system in which they learn skills specific to that area. "We're getting ready now to bring on board those folks who are willing to be a mentor — not everyone is cut out for that."

3. **Cross-training.** Once employees have mastered the information specific to their area, the plan is to cross-train them so they will be proficient in any registration setting. That plan is on hold while the organization focuses on building the staff necessary to take on preregistration as a centralized function, she notes.

4. **Annual competency fair.** Any employee who registers patients will participate in this event, to be held every June at one site. "People will walk through and stop at different stations," Underbrink explains. "One might focus on insurance plan codes, to make sure they're proficient at that. At another, they might sit down and be asked to register a patient. We'll make it fun, while ensuring that everybody has the knowledge they need."

5. **Annual inservice on insurance plan codes.** In November, St. Vincent held six educational sessions focused entirely on insurance plan codes. Every registration employee was required to attend. "This is a joint project between patient financial services and patient intake," she says. "We struggle constantly with trying to match insurance cards to our codes." In the sessions, employees provide feedback on how to make the hospital's insurance table more user-friendly. "We learn as much from them as they do from us."

To further promote quality improvement, the new auditors are developing various reports that will provide feedback on the registration process, Underbrink says. "The employees really want to do a good job, but they haven't always gotten timely feedback."

Her department's efforts already have had some impact. We've been able to provide feedback to those who don't report to the central department — the unit representatives, for example. Their role is changing, but they won't go away."

In addition, she says, "We're providing the results of manual audits and also some electronic reporting on critical data fields that aren't completed. We've added a new mandatory field for the primary care physician, which is one of the things we're monitoring."

The error rate has gone down in a couple of instances, she adds.

The real benefit is in being able to work with registrars on how to perform the task properly. "We will manually look at face sheets and give feedback, but we will try to do as much electronically as we can."

In December 1998, her department began giving each registration area and its manager a report card, she says. "It will say, 'You've had this many registrations and this many errors. This is how many multiple registrations you've created.' If we identify a particular area with a problem, the trainers will go there and do special coaching. Or it may be that everyone will need extra help in the beginning."

The idea is to look for trends, areas everyone is having difficulty with, and to be aggressive in addressing potential problems. "We want to give them the tools to do their job." For example, auditors have discovered inconsistencies in the way consent forms are completed. "We are getting that corrected."

(Editor's note: Look for a closer examination of St. Vincent's decision to move back to centralized registration in a future issue of Hospital Access Management.*)* ■

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Screening can ease medical necessity burden

Software flags wrong code during phone call

When it comes to complying with Medicare's medical necessity rules, the issue is "where you police the system and who polices it," says **Balil Ezzeddine**, PhD, imaging research and development director at Kettering (OH) Medical Center.

Physician orders should be screened for medical necessity at the point of scheduling, contends Ezzeddine, whose hospital is a beta test site for a new medical necessity module by Jacksonville, FL-based Tempus Software. The medical necessity software, Comply, works with Encompass, the vendor's enterprise patient scheduling product.

Hospital staff who attempt medical necessity screening at the point of service have missed an opportunity to handle the situation through a phone conversation between schedulers and the physician's office, he says. "When a physician who is not trained to give the right ICD-9-CM code orders an exam, his ignorance trickles all the way back to the billing department. How do you start policing so in the end you educate all the physicians to learn to use coding principles and guidelines?

"We have to start making checkpoints and try to feed the information back to the physicians. The best checkpoint is at scheduling."

"There's no way we can immediately educate all physicians, so at the same time we have to start making checkpoints and try to feed the information back to the physicians," he adds. "The best checkpoint is at scheduling. That's when you want to put in a filter to say [to the physician], 'If you're giving me the wrong indication for this diagnosis, please fix it.' You don't have to call the physician back [or] track him down."

Screening during scheduling also eliminates the awkwardness of having the patient sign a waiver — on the spot — accepting responsibility for the cost of the procedure if it fails medical necessity, he notes. Instead of learning there's a problem as they wait to have a procedure, patients can be notified well in advance.

With Encompass Comply, the scheduler selects the patient, the procedure, and the ordering physician on the computer, explains **Matt Lang**, director of marketing for Tempus. Encompass prompts users for the ICD-9-CM diagnosis codes, allowing them to select from a pre-defined list of valid codes. The system checks the combination of diagnosis and procedure (CPT-4) codes against lists of appropriate code combinations, Lang says. "It will either accept the ICD-9-CM or flash a warning saying this diagnosis does not meet guidelines."

If a physician has given a diagnosis that doesn't match the selected procedure code, Comply will prompt the user to have the patient sign a waiver, which can be faxed or e-mailed to the physician's office while the appointment is being scheduled, adds **Nidal Kanadilo**, a programmer for Tempus Software. "While the physician or the nurse is on the phone, [he or she] will see a printout of the waiver."

The software will accommodate an unlimited number of user-defined payer databases, allowing each hospital to match its exact payer mix, Lang says.

At Kettering Medical Center, if the physician's order is noncompliant, a waiver is faxed to the physician's office, along with the scheduling materials to be given to the patient. The system also generates an "exception log" that records each incidence of noncompliance. "It will eventually generate charts," Ezzeddine explains. "If the physician is again and again scheduling a particular exam that is not indicated, we will go back to the physician and say, 'What are you doing?'"

One of the hospital's major concerns, he says, was ensuring that the scheduler would not be the one deciding whether to accept or decline a procedure. Another key issue was how the necessary information would make it all the way to the bill, Ezzeddine says. "When a patient has to sign a waiver, billing needs to know that, so it won't bill the insurance company [or Medicare], because that would be double billing."

The information is sent to the billing department by way of the HL7 communication module, Encompass Connect, Lang says. This interfacing technology enables scheduling information, including CPT-4 and ICD-9-CM codes, to be shared with other systems such as billing or claims editing, he explains.

What billing receives, Kanadilo says, is a

schedule information update message, which consists of fields for these pieces of data:

- patient;
- visit;
- schedule, including data and time of appointment;
- scheduled procedure, including CPT-4 codes;
- resources scheduled;
- diagnosis codes, including ICD-9-CM.

"If Comply issues a waiver to the patient, the procedure is flagged until the waiver is returned," Lang says. "If the patient forgets the waiver, the hospital can run a report and have an extra copy available before and when the patient arrives."

Once the waiver is returned to the hospital, the system is updated with those data, as well as whether the procedure was canceled, the patient should be billed directly, or a new diagnosis has been provided, he notes.

"The billing department is kept informed because Encompass automatically passes this information to the hospital billing system," he points out. "The billing department can simply review the pre-screened CPT-4/ICD-9-CM coding and issue the patient's bill through the appropriate channel."

If a procedure is canceled or changed upon the patient's arrival, the hospital cancels or reschedules it through Encompass, which automatically notifies other systems — such as billing — of the change.

Encompass Comply underwent beta testing at two client hospitals, including Kettering, and is scheduled to be on the market in the first quarter of 1999, Lang says. In addition to containing Comply, he adds, Encompass 7.0 has the following new features:

- multiple physician scheduling;
- patient alias names for security and privacy;
- Oracle database support in addition to the Advantage Database Server currently supported;
- new graphical user interface design;
- common object recognition broker architecture, which provides an independent platform for the scheduling engine. ■

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Advance your career by watching TV

Prepare for change, accept it gracefully

In the past few years, there's been an "implosion" of opportunities for access managers, with departments being combined, "value vs. pay" examined, and downsizing the order of the day, says **William Giwertz**, MBA, CHAM.

With so many middle-management positions in flux across the industry, access managers are well advised to prepare themselves for change, says Giwertz, financial systems and special projects analyst for Los Angeles-based Cedars-Sinai Health System and a frequent speaker to professional health care organizations.

At one gathering of health care managers, 85% responded affirmatively when he asked if they'd seen or experienced a "slash-and-burn" reorganization in recent months. "Many people [in access management] are about to face unemployment, or being pushed and shoved three levels down, after two or 20 or 35 years. How do you insulate yourself for such a process?"

Recover gracefully

The best course of action, he says, is to prepare, if possible, or to recoup and recover gracefully after the fact, if faced with one or more of the following scenarios:

- Your role is downsized.
- Your position is eliminated.
- Your department/functionality is merged with another.
- You're told the organization no longer needs as responsible a person/position for this role.

Giwertz says he is aware of access managers who faced such a situation and thrived, thanks in part to their efforts to remain up-to-date on the latest technology and to complete a master's degree in business administration.

One of the keys to survival is further education, he stresses, and the opportunities for obtaining it are increasingly flexible. "There are fully accredited, matriculated evening classes for adults, as well as Internet courses available. It's not just the same old Management 101. Topics include business strategy, business plan preparation, and the strategic work of Tom Peters."

As the focus at most health care organizations

turns from mainframes to PCs and servers, it's easier to gain proficiency in computers, he points out. "At least get very familiar with Microsoft Office programs. An ability with basic office customization programming could put you a cut above others applying for positions."

Since hospital access services is most often associated with the organization's finance department, learn more about finance, he advises. "Know what a balance sheet is, gain more of an accounting flair." The Washington, DC-based Healthcare Financial Management Association's Web site offers a wide assortment of books along this line, Giwertz adds**.** (That Web address is www.hfma.org.)

For a rich source of ongoing educational offerings, he says, not only watch but join your local Public Broadcasting System affiliate. "Put it on your calendar if Tom Peters, who published *In Search of Excellence,* is going to be on," he advises. "In another [program], excellence in the nonprofit sector is examined. Peters examines everything from Southwest Airlines to the police department in Chicago, looking at what they do that has made them the best."

Leave diplomatically, appropriately

Access managers who, despite their best efforts, find themselves on the wrong side of "right-sizing" should handle the news graciously, he says. "So many people react emotionally to bad news, and I can't blame them. The vast majority say things like, 'I've been here 30 years. They're going to do an awful job if I go away.'"

It's not the kind of reaction that will help you come out ahead, he says. "You've put the organization first for a long time, and now it's time to put yourself first. Leave diplomatically and appropriately." The idea is to find other employment and to recapture the passion you had at the beginning of your career, Giwertz says. "Those who react negatively tend to have a bad job search. If you concentrate on that negative, you will bring in the negative."

At the same time, don't be shy about going after the best severance package possible, he says. "Don't be reluctant to renegotiate." Point out your contributions to the organization. It might help if you've kept an informal file of the things you've done well, including commendations from patients and major admitters. "Pursue the prospect of consulting, either within or outside your current organization," he says. ■

Like providers it oversees, HHS prepares for 2000

The U.S. Department of Health and Human Services (HHS), like many of the health care providers it oversees, has made the year 2000 (Y2K) computer problem its highest information priority, according to a recent report.

In its May 1998 quarterly report to Congress, HHS reported 289 mission-critical systems. HHS mission-critical systems pay Medicare benefits, provide billions of dollars in grant payments, collect and analyze epidemiologic, clinical trial and other public health data, and track health care spending and other data. About 52% of these systems are now Y2K-compliant.

Last-minute effort

The total cost of ensuring HHS systems are Y2K compliant is estimated at $288.6 million. To help the Medicare program meet the HHS secretary's goal, the department allocated an extra $41 million in fiscal year 1998 by drawing on discretionary funds from each of its operating divisions. The fiscal year 1999 budget provides HHS with $190 million in emergency funds for Y2K conversion, $112 million of which is targeted for the Health Care Financing Administration (HCFA).

To be considered Y2K compliant, computer systems must be able to read and process date information beyond the year 1999. The systems also must have been field-tested and subjected to independent verification and validation, and they must be up and running. There are three ways to correct the date problem: Replace the system with a compliant one, repair the date fields, or retire the system if it is no longer needed.

Here are three generally accepted methods of repairing date fields to achieve Y2K compliance:

- **Date expansion.** This is the most straightforward and complete method of ensuring Y2K compliance. Date expansion involves changing computer codes so the computer recognizes a four-digit year instead of assuming the first two numbers are "19." Most HHS computer systems will be updated using this method.
- **Windowing.** This process creates a window of time and tells a computer system to treat two-digit dates as 20th century if greater than a certain number and 21st century if less than a certain

number (for example, 1936-2035). Windowing, however, is not appropriate for use in all computer systems.

• **Program logic or "electronic bridging."** This method makes noncompliant data look compliant when they reach their destination. Electronic bridging is used mainly as a method of compliance for data exchange between two parties.

Of all HHS programs, the Medicare program, administered by HCFA, faces the biggest challenge in preparing for the year 2000. Payment of health care bills by the program is run by more than 60 external contractors, which operate and maintain a base of software programs that process nearly a billion claims each year from more than a million health care providers.

HCFA has made changes to Medicare contracts requiring Y2K compliance and released guidance with more useful definitions of compliance and testing requirements. (See www.hcfa.org.) All of the external Medicare contractors have completed assessment of their systems.

To help ensure contractor compliance, HCFA is undertaking two critical steps:

• dedicating additional resources to Y2K remediation;

• delaying implementation of a small number of new initiatives to make sure Y2K remediation efforts are completed first. ■

Tracking data is key to better ED outcomes

Reducing waits and delays is critical to improving outcomes in emergency departments (EDs), emphasizes **James Espinosa**, MD, FACEP, FAAFP, chairman of the department of emergency medicine at Overlook Hospital in Summit, NJ. "It can save the lives of patients with heart attacks and strokes and can affect patient satisfaction, costs, and quality of life for our patients and our caregivers," he says.

The Boston-based Institute for Healthcare Improvement recently took on that challenge with a unique collaboration. Thirty-one EDs began an intensive, seven-month effort in April 1998 to reduce delays and cycle times, with the goal of achieving improved health care outcomes, more timely service, and higher levels of patient and family satisfaction.

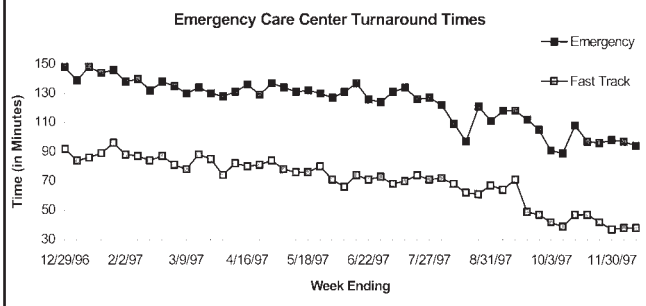
To monitor progress during the project, each ED tracked the following criteria: total length of stay, length of stay for admitted patients, length of stay for ED patients, length of stay for fast track, presentation to physician evaluation, and admission cycle time. "Not every ED has a tracking system, so you need to learn how to collect data easily and in real time, with the least effort possible," says **Linda Kosnik**, RN, MSN, CEN, unit manager for the ED at Overlook and co-chair of the collaborative.

For EDs without an electronic information system, a data collection form was provided that incorporated sampling, says **Kevin Nolan**, a statistician at the Silver Spring, MD-based Associates in Process Improvement, who worked with participating EDs. "Records were selected each day for patients, with data summarized weekly using a median," he explains. "The medians are plotted on a run chart to monitor progress, along with data on clinical cycle times and patient satisfaction."

Several weeks before the collaborative started, each ED was sent information that outlined the basics of data collection, including sampling. "At the first learning session, we talked to the whole group, showed examples, and worked individually with those groups that had problems or questions," says Nolan. "As the teams send in their progress reports, we give them ongoing feedback on their data collection and visual displays."

Sampling data is a simple, efficient way to understand how a system is performing, says

Emergency Care Center Turnaround Times



Source: Nash Health Care Systems, Rocky Mount, NC.

Espinosa. "It's astonishing that even relatively sophisticated ED managers as yet do not appreciate the power of sample data displayed as a trend. We have, by and large, been reared on pre- and post-intervention systems, comparing two cuts of data and looking for the difference between the two groups. That is the shape that tends to emerge from clinical trials."

The work of daily sampling calls for a different skill set than many managers are familiar with, says Espinosa. "The whole point is turning data into a picture which is simple and compelling. Charts can be enlarged and colorized, and placed near a coffee machine, which creates a storm of buy-in from staff."

At Nash General Hospital in Rocky Mount, NC, sampling data and trending over time was found to be a cost-effective way to measure progress, says **Kirk Jensen**, MD, medical director of the department of emergency medicine.

"At first, we thought we needed to wait for a $30,000 computer system. We do this all by hand, and have learned that if we sample four charts a day over time, we do get an accurate view of where we are going," he explains. Two charts are selected at four items per day for three types of patients: emergency, fast track, and admissions.

No need for pricey tools

The method has proven itself over time. "Eighteen months later, we are still doing it by hand with secretaries, student volunteers, and people who answer the radio," Jensen says. "In fact, the less involved the individual is with the department, the more pristine the figures."

There is no need to invest in high-priced tools, Espinosa advises. "In emergency medicine, there is an immense amount of attention paid to selecting sophisticated digitized tools with a cycle time measured in years from implementation. But there is very little practical experience or evidence in how these tools are going to change systems," he says. "The data does not jump out of a box graph itself and find its way to an administrative office, or the hearts and minds of workers in the ED."

Teams measured their progress with an annotated time series. **(See Emergency Care Center Turnaround Times graph, p. 10.)** "Making both the problem and progress visible builds support for continuing to make the changes necessary to reduce delays," Nolan says. ■

NEWS BRIEF

Growth in spending stable in '97

Health care spending in the United States rose only 4.8% in 1997, the slowest increase in almost 40 years, according to a report released by the Health Care Financing Administration (HCFA). HCFA reports that health care spending in 1997 totaled $1.1 trillion, with per-person spending, on average, at just under $4,000.

Longer-term HCFA estimates, however, anticipate that health care spending will grow more rapidly in the coming years.

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The report by HCFA analysts shows that the gap between health spending paid for by public and private sources inched closer in 1997, continuing a trend that began in 1990. Private funding paid for 53.6% of health care in 1997 ($585.3 billion), down from 59.5% in 1990, while public programs, including Medicare and Medicaid, paid for 46.4% of health care in 1997, up from 40.5% in 1990.

Spending down in private sector

The overall slowdown in health care spending has been driven largely by rapidly falling growth in private spending, which reached an all-time low growth rate of 2.3% in 1994. In addition, since 1994, the rate of spending from public funding sources, primarily Medicare and Medicaid, has slowed, contributing to lower overall spending growth.

Total Medicaid spending increased only 3.8% in 1997, to $159.9 billion, the slowest growth since Medicaid's inception nearly 30 years ago. Preliminary data suggest the slowdown can be attributed to decreases in Medicaid enrollment in 1995, 1996, and 1997, as well as reductions in the rate of spending growth per enrollee.

Expenditures for hospital care accounted for 38% of personal health care spending and were the slowest-growing service, increasing only 2.9% to $371 billion in 1997. Spending for physician services increased 4.4% in 1997, continuing a trend of single-digit growth started in 1992. ■

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