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INSIDE

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Bedside registration is 'gold standard' for care in Iowa emergency department

Patients and clinicians love the new system

Bedside registration is "the gold standard" for care in the emergency department (ED), ensuring EMTALA compliance as well as patient privacy and satisfaction, says **Mary Miller**, RN, manager of access services at Mercy Medical Center (MMC) in Sioux City, IA.

Concerned that upfront ED registration could be misconstrued as an effort to obtain financial information before treatment, the hospital implemented bedside registration in July 2000. Also fueling the move was a registration booth design that at the time was not particularly conducive to patient confidentiality, she notes.

"Patient satisfaction surveys and comments have shown that patients and their families love it," Miller reports. "If a patient has been taken back for treatment and family members are kept out front to give information, they may not care about [the accuracy] of what they give. When [registrars] go to the bedside, patients just love it. They sit there and see that they're not missing the doctor; and it's really private because the patient has his or her own room."

"[Bedside registration] has reduced wait time considerably," notes **Nancy A. Jackson**, MSW, LISW, interim director of revenue cycle systems. "Another [patient satisfier] is that we don't ask the same questions at three different points." Previously, she adds, patients might have been asked for the same demographic information when they arrived at the triage area, when they entered the ED, and again if they are admitted to an inpatient unit.

"With bedside registration," she explains, "once the information is entered by that registrar, it automatically goes into the computer system. Demographics are pulled up and attached to the nursing assessment so the nurse doesn't have to re-ask those questions. It has really reduced the anxiety and frustration on the part of patient and family."

The average ED registration — from the time the patient presents at the front desk to be triaged until the chart prints — takes seven minutes,

The Seven Standards of Service Care at Mercy Medical Center

- **Standard One: Make positive first impressions our first priority.**
  Create a positive, professional image within Mercy.
- **Standard Two: Treat others as "guests."**
  Treat everyone as a VIP and help them feel valued.
- **Standard Three: Develop "service recovery."**
  Turn negative situations into positive experiences
- **Standard Four: Communicate effectively.**
  Improve the ways we communicate with others
- **Standard Five: Serve others from a team-centered approach.**
  Erase barriers between departments and focus on serving.
- **Standard Six: Project a positive attitude.**
  Improve attitudes and performance throughout the organization.
- **Standard Seven: Make excellence the goal in everything we do.**
  Challenge each individual to strive for personal excellence.

Source: Mercy Medical Center, Sioux City, IA.

adds Miller. "If we have had a call and know the name in advance, we can have the chart ready when the patient comes in."

Registration times for all patients have been monitored since the early 1990s, she notes, but the most dramatic improvements have taken place in the past two years. **(See related story, p. 100.)** Further enhancing customer service is the ED physicians' policy of not keeping patients waiting more than 30 minutes, Miller points out. "Usually, it's more like 10 minutes**." (See MMC's standards of care, above.)**

In another benefit to patient care, Miller says, "the nurse who triages the patient finds a physician immediately and says, 'This is what's going on with the patient; this is what I've done.' He can tell [the nurse] to get certain things started."

In other cases, she notes, the nurse may tell the physician that he must see the patient right away. "The physician has a good idea of [the condition of] each patient as quickly as the nurse does."

The registration process works as follows, Miller explains. The patient comes in and is greeted by the triage nurse, who assesses the acuity of the condition and takes the patient back to a treatment room. The nurse goes to a white board, located near the nurses' station, and puts an "A" (for access) next to one of the room numbers listed there. **(See the ED registration flowchart, p. 99.)**

"The registrar, who could be either out front or in the back registering another patient, sees that there is a patient in Room 10 who needs registering," she adds. The ED nurses' station, Miller notes, is back-to-back with the registration station.

"If the physician comes in and the registrar has to step out, that's fine," she says. "We're happy to do it. A lot of the time, the patient is so bad that the physician just says, 'Stay here and get what you can.'"

Information is entered into the computers in real time and then printed out near the nurses' station, Miller adds. Registrars take consent forms and copies of patients' rights and responsibilities, including advance directives, to the bedside as well, she says. "We give [advance directives] to all patients coming through our system, not just inpatients."

At present, registrars make a copy of the patient's insurance card or ID when they go to the chart room to put the charts together, she notes. "We hope to have a scanner in the future."

When a patient comes from an accident scene, for example, police take billfolds and purses, Miller says, so it can be a long time before registrars get access to patient identification. "We start with a blood bank ID, a red armband with just a number issued by the lab people that is specific to that patient. Any of the lab work or tests that are done will tie in to that number."

There are two registrars on duty for the day and evening shifts, she notes, and one person doing registration from 11 p.m. to 7 a.m.

If the triage nurse is in the treatment area,

(Continued on page 100)

COMING IN FUTURE MONTHS

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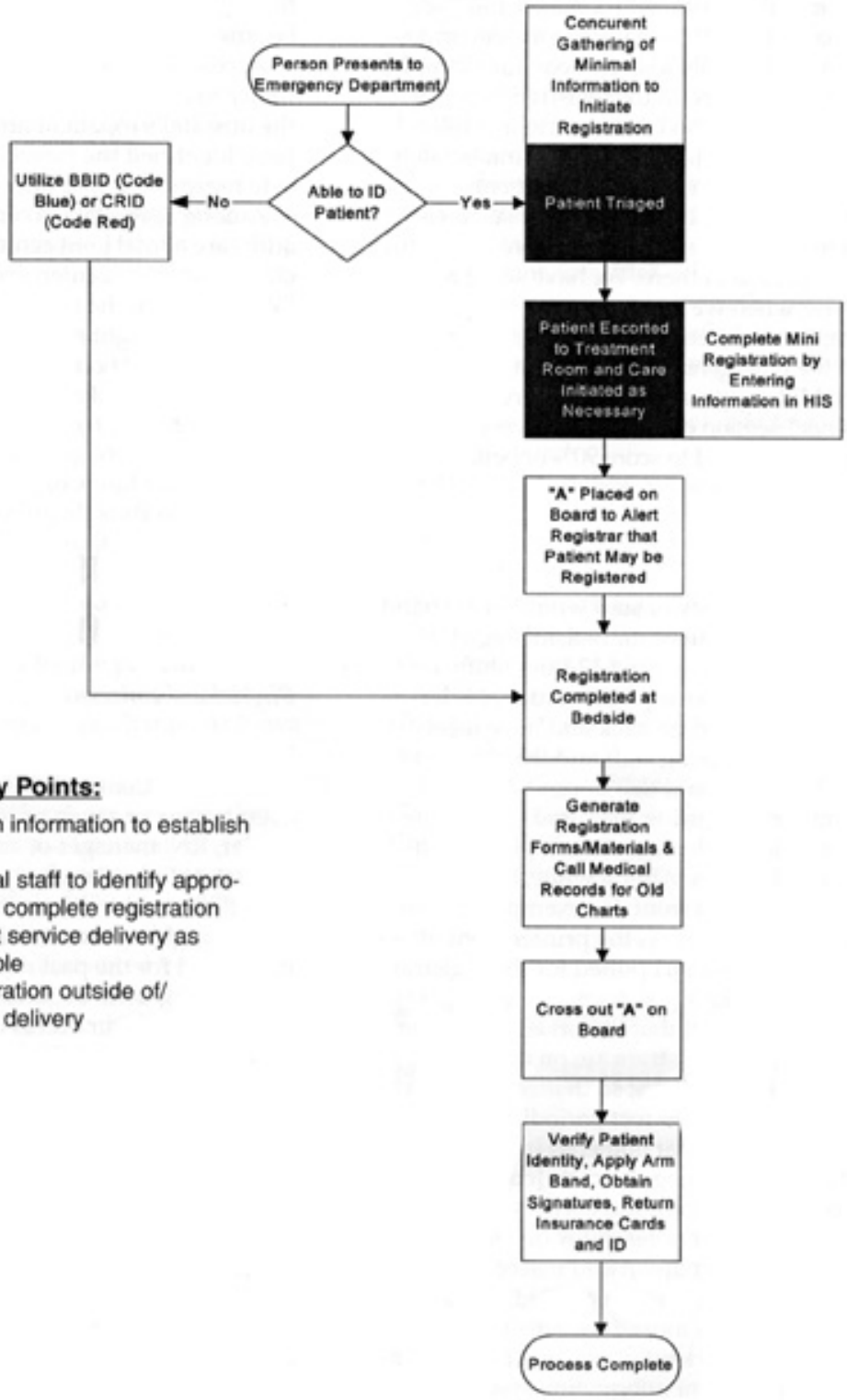
Mercy Medical Center ED Registration Flowchart



Key Points:

- ✔Gather minimum information to establish account
- ✔Work with clinical staff to identify appropriate interval to complete registration
- ✔Facilitate patient service delivery as rapidly as possible
- ✔Complete registration outside of/ adjacent to care delivery

Source: Mercy Medical Center, Sioux City, IA.

having taken another patient back for care, when someone arrives, Miller says, the registrar out front can either ask the person to wait for a moment or run to the back to get help, depending on the person's condition.

"Sometimes the treatment rooms are full," she adds. In that case, the triage nurse may determine that the person has only a sore throat, for example, and can be interviewed in the registration booth up front. If the condition is more serious, Miller says, the nurse takes the patient back immediately, possibly displacing a nonemergent patient.

"We do have an ambulatory diagnostic area [adjacent to the ED]," she notes, "so we could put a less acute person in there. We have some room to improvise when we need to."

The hospital is extremely committed to compliance with the Emergency Medical Treatment and Labor Act, Miller says, and has an inservice and "skill-builder" session on the subject every year. Registrars are required to score 90% or better on a related questionnaire, she notes.

Staff preparation

To ensure that plenty of staff would be on hand during the learning curve for bedside registration, all the registrars worked 12-hour shifts for the two weeks prior to implementation, Miller says. "Then we would go back and have meetings with the ED nursing staff and the registrars and say, 'This works and this doesn't.'"

It was important during that time to have the overlap provided by having three registrars on duty at once, she adds. After a while, Miller notes, the registrar up front, for example, got into the routine of — as soon as the printer went off — getting the patient's chart pulled for the registrar working in the back.

Staff also discovered that it worked best if the "front" and "back" registrars are on a one- or two-hour rotation, she says, so that each person has a chance to be off her feet periodically.

"One of the things that bothered [the registrars] at first was pushing the carts [containing the laptop computers] around corners and down different halls," Miller notes. Now one is kept sitting in a hallway, shut down and inaccessible if not in use, but available when needed, she adds.

The department has four of the carts with laptops, two of which are kept in use, and two that are kept in the management information systems area being charged and checked, she says.

One of the initial hurdles to implementation was nurses' concern that bedside registration might delay or interfere with care, she notes, but that concern appears to have been alleviated. "Sometimes [nurses] forget to put the patient's name on the board, so we have to quickly get in there [and do the registration], but that's just because they're busy."

Access staff are looking forward to the opportunity to extend bedside registration to some of the hospital's inpatient areas, notes Jackson. "We have identified the possibility of expanding bedside registration into our Centers of Excellence."

Among several such centers at MMC, she adds, are a total joint center, a stroke center, a child protection center, and an obstetrics center. "We are one of the top 100 heart hospitals in the country, and right now are building a multimillion-dollar heart center."

[Editor's note: Mary Miller, RN, may be reached at (712) 279-2218 or by e-mail at millermf@mercyhealth.com.] ■

Tighter system reduces registration to 6-7 minutes

Physicians' concerns sparked effort

Registration times for patients at Memorial Medical Center (MMC) in Sioux City, IA, average "six or seven minutes," says **Mary Miller**, RN, manager of access services.

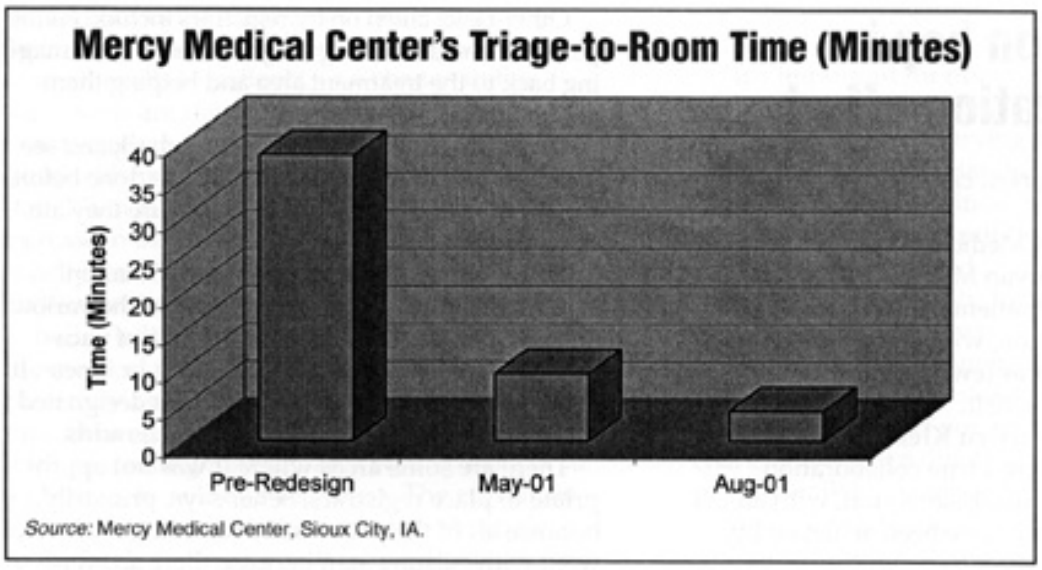
That includes "anybody who comes in for anything," she adds. "We really work to keep it there."

Although registration times at MMC have been monitored for the past decade, a renewed focus on reducing them began a couple of years ago, Miller notes. "Our access director at the time came to me and said he had committed the department to registering same-day surgery patients in 15 minutes or less."

"The physicians didn't want the surgery time delayed," Miller explains. "They were extremely unhappy if we were unable to meet 'table time,' which is the time they want to actually begin the surgery. We committed to meeting that time."

In the past, she notes, the problem had been that patients occasionally would not be ready at the appointed time, and there would be a "domino effect" that backed up the rest of the day's procedures."

To facilitate the process for those patients,



Miller says, staff put big orange dots on those registrations. "Now we use stars, but it tells us this is a same-day surgery patient and to give that patient priority. We found that when they're moving through faster, other patients are, too."

Putting a bigger emphasis on preadmission was one key to the reduced registration time, she notes. "The more pre-admit charts we have, the less time it takes."

Designating an access nurse to greet incoming patients, prioritize them, and move them quickly into registration booths also speeds up the process, Miller notes. "[That nurse] is constantly watching [as patients arrive]. We don't want patients to even sit down in the waiting area if they don't have to."

To make sure the system works, Miller sits at the registration desk between 6 a.m. and 8 a.m., during the time the same-day surgery patients begin arriving, she notes. "I make sure that as soon as the patient comes in, the next registrar has that patient."

With 150-300 patients a day coming through, it's important that the first surgical procedures begin on time, Miller says. Registrations for a chest X-ray — which doesn't have a scheduled time — aren't as time-sensitive, she adds.

"It's like having an extra registration booth," Miller says. "I am at the front desk with the volunteer signing patients in. If the booths are full and the patient has a pre-admit chart, I place the face sheet in front of [the patient] and ask if it's correct. While I'm getting the signature, the volunteer is copying the front and back of the insurance card."

An interesting discovery has been that patients "love reading it," she adds. "They really read it carefully, line by line, and say things like, 'No, that should be an eight instead of a six in my mother's phone number.' It's their information, and we [traditionally] don't let them see it."

Regarding the admission of inpatients, Jackson explains, physicians were unhappy that, as a result of data gathering, it was taking a long time to get their patients into a bed. **(The facility's triage-to-room time fell dramatically; see above chart.)**

"Part of the problem was slow people in the central registration area," she says. "We made some changes not only in work flow, but in the area itself. We have done major renovation and remodeling in the past two years."

The registration booths, which before could not be easily accessed by a person in a wheelchair, have been put in a different configuration and are more user-friendly, Jackson says. The new arrangement also is more conducive to patient privacy, she notes, which was a major emphasis in the redesign.

About four years ago, Jackson says, the hospital developed a revenue cycle system that has provided the framework for the recent improvements. Included in that system, she adds, are patient financial services, which comprises admitting and registration, clinical information systems (medical records), and case management services.

A recent report from the National Registry of Myocardial Infarction reveals another impressive statistic to which registration efforts have contributed, Miller points out. MMC's "door-to-dilatation time" — the time between a patient's arrival at the hospital and inflation of the balloon for a primary angioplasty procedure in the cardiac catheterization lab — is 69 minutes, she says. "The average in Iowa is 94 minutes, and the national average is 104 minutes."

Registration plays a part in that figure, Miller notes, "because registration doesn't hinder or delay [the process] in any way, yet it's done so the record is there." ■

Collaboration key in decentralization effort

Nurses, registrars worked closely

When BryanLGH Medical Center in Lincoln, NE, built the Bryan Medical Plaza in 1993 to better serve its outpatients, the emphasis was on customer satisfaction, with a goal of having the patient encounter as few faces as possible during the course of a visit.

That effort, says **Marilyn Klem**, admissions manager, was fueled by a true collaboration between clinical and admissions staff, with an outcome that could not have been achieved by either side alone.

In the past, explains **Shelly Seher**, registration manager, outpatients were registered in a central admitting area and escorted by a hospital volunteer to the appropriate ancillary department, where they checked in with a receptionist and waited for a technician to call for them.

Now patients directly report to the point of service, with registrars on duty in eight outpatient areas, she notes. Those include cardiovascular and radiology services, the hospital's specialty clinics (where such services as preadmission testing, physician consultation, and patient education are offered), outpatient surgery, and off-site locations such as the mammography center, Seher says.

After looking at patient volumes in the various departments and determining the staffing needs, Klem adds, she and Seher rewrote job descriptions to include the new duties the registrars would be assuming. (Both Klem and Seher report to the director of patient financial services.) As registrars were dispatched to the ancillary areas, she notes, there was a corresponding drop in those working in the main admissions area.

Registrars' responsibilities in the outpatient areas include tasks that are not clinical per se, but rather "clerical duties within a clinical [setting]," Seher says. "They're answering the telephone, stamping patients' charts, taking charts back to nurses, and in some areas, entering physician orders. In some cases, they stock the fridge with patient preps, order medical records, and call patients [regarding] clinical appointments."

"These are things not typically done in the admission area," she adds. "On the inpatient side, [registrars] handle orders, but not the handling and stamping of charts."

Other tasks taken on by registrars include taking patients who are having magnetic resonance imaging back to the treatment area and helping them get undressed, Klem says.

"In radiology," Seher adds, "they check and see if certain [required] lab tests have been done before a procedure and, if not, call to make sure they are done so there is no delay."

Five years ago, Seher added four "flotation" staff members, to fill in for registrars in the various areas, she notes. They cover in the case of vacations, maternity or educational leaves, or illness. In all, there are 16.1 full-time equivalents designated for registration in the medical plaza, she adds.

There are some areas where it was not appropriate to place registrars, Seher says, primarily because all of the patients are recurring. "We went with existing staff because there are very few new patients, and the bulk of the work is truly administrative — not registrar work."

In the case of another area, the volume was so low — 10-12 patients a day — that a radiology tech was trained to perform the few necessary registrations, she says.

In most of these areas — which include health enhancement services, physical therapy, and sports medicine — administrative secretaries are cross-trained to do registrations, Seher says. They report to their respective clinical managers.

These employees receive a focused one- or two-day training session with competency validation, she adds. "We look up [the source of] any errors and send them back to that employee."

Monthly meetings held

Seher, who oversees outpatient registration, and the registration supervisor for the medical plaza meet with the outpatient registrars on a bimonthly basis, she says. "They give us input, and we do team-building exercises."

The registration supervisor and the registrars in the different clinical areas also meet — quarterly or as needed — with the supervisors and managers in the areas they serve, she notes. This meeting offers an opportunity to go over staff responsibilities, resolve problems, and talk about any new services that might be planned, Seher adds.

At both meetings, she says, registrars "take an active role in bringing up issues and brainstorming solutions. Unless the concerns are urgent, we ask them to table their concerns until the meeting and submit agenda items five days in advance."

Topics of discussion in the area meetings might

include physicians in the pain clinic changing their schedules, a new procedure for making reminder calls to patients, or a change in the way charts are stamped, Seher says.

Although the move to decentralization has coincided with an increase in admissions/registration staff, Klem says, some of that jump is due to an increase in the number of outpatients treated. "Shelly tracks the numbers on a monthly basis to make sure the staffing is where it needs to be."

In line with the focus on customer service, the medical plaza is designed so that patients can easily and directly walk to the point of service, Seher points out. "It's designed like a mall, with an awning for each area so they can see at a glance where they need to go. The entrances are in a U-shape, but the departments go deep to the back. Patients aren't going down corridors looking for the right area."

One of the "learning points" for hospitals considering a similar move — and one her staff will keep in mind as they work on the spring 2003 expansion of the medical plaza at the hospital's west site — is to begin the departmental collaboration right away, Seher says.

"It's important for nursing to get registration people involved early on," she explains, "so they're not at the end trying to find a space for registrars." An understanding of the flow of the clinical operation is critical, she adds, to determine the best place to put the registrars and the kind of space they need."

Patient confidentiality, for example, is a big concern, Seher says, as is easy accessibility, proper signage, and space for printers and other equipment.

"You need to understand the entire clinical piece," she adds. "If you're going to be stamping charts, you want a different kind of work area, a path to walk in. A design for a clinic is different than one for radiology."

The continuing focus, Seher points out, is on facilitating the clinical processes. "We are there as frontline support. Everything we do is to support [the nurses]. The nursing documentation is stamped and ready to go, and they don't have to work [on clerical tasks]." ■

ACCESS FEEDBACK

MSP ruling prompts questions, concerns

Continued 're-asking' is a problem

Denise Leapaldt, admissions supervisor for Jamestown (ND) Hospital, a 56-bed facility, offers feedback on two topics that were addressed in the July 2002 issue of *Hospital Access Management*.

The first issue, Leapaldt says, concerns Medicare Secondary Payer (MSP) questions and the new ruling that MSP information may be up to 90 days old for reference lab claims. "I agree that monitoring the MSP questionnaires for up-to-date information is tedious and cumbersome," she adds, "but I believe that being able to use 90-day-old information is much better than having to obtain new answers to the same questions for each reference lab."

"I maintain a manual database for all Medicare patients having nonpatient labs," Leapaldt says. "Many times, the lab patient has a nearly corresponding date of service at our hospital for another service, so the MSP information from the outpatient/inpatient account is current. I document the date that the initial MSP information was obtained, the date it will be nullified, the account from which I am taking the information, and the name of the person who supplied the MSP information."

One of her biggest complaints with continuous re-asking of MSP questions is explained by the following example: The patient is an 85-year-old widow at a local nursing home. She routinely has reference labs sent to the hospital for a diagnosis of high-risk meds. She never has suffered from black lung disease or end-stage renal disease. This test is not due to an injury. She has no Veterans Affairs (VA) insurance, and she is not involved with a government project where that agency would pay the claim. Obviously, she is entitled to Medicare because of her age. A previous MSP questionnaire states that she never worked outside the home, so she has no retirement date. She is a widow; so there is no spouse's retirement date.

"What is ever going to change for this patient unless her claim involves injuries due to a motor vehicle accident or liability?" Leapaldt asks. "We receive the reference lab claims for her with a diagnosis that is obviously not due to an injury.

What else would change? Is she suddenly going to have VA insurance? No. Will she ever be entitled to Medicare because of end-stage renal disease or a disability? No. Is she going to begin a career sometime soon, retire, and now have a retirement date? No."

Leapaldt once interviewed a patient twice in one day, and when asked the retirement date, the patient gave dates that differed by five years. Is this accurate information? After all, the patient verbally gave two different dates.

Repeatedly asking family members or patients for answers to these questions is time-consuming for registration employees and often irritating to the patients' families. "We consistently hear, 'Nothing has changed,' or 'We just gave you that information a few days ago,'" she says. "I advise my staff to tell families, 'I'm sorry, but we are required to ask these questions each and every time you come to the hospital. If you would like to protest this practice, please write to your congressman."

Leapaldt says that in an ideal world, hospital registration people would be trained to recognize the scenarios described above, and could register that nursing home patient accordingly but currently are unable to do so because of MSP rules.

"Unfortunately, in the past, facilities filing fraudulent claims have necessitated the formation of rules that hamper quick and efficient registration processes for the rest of us," she says. "We do everything we can to ensure that the claim is filed correctly, such as obtaining copies of insurance cards, verifying insurance coverage, and making necessary phone calls to question the reason for the patient's visit."

The people making the rules regarding MSP questions should visit a hospital registration area and witness the difficulties encountered when trying to obtain correct MSP information, Leapaldt suggests. "More often than not, it is frustrating and unsuccessful, resulting in phone calls to the patient's relatives who live elsewhere," she explains. "Do the relatives know if the patient has VA insurance? Do they have any idea of that patient's retirement date? The answer to both is a resounding no."

Regarding another access issue — the challenge registration employees face in getting consent for admission forms signed — Leapaldt shares a solution her facility devised with its obstetrics (OB) department.

Since OB patients arrive at all times during the day and night and the admissions department is not staffed between 11 p.m. and 6 a.m., she explains, the window of opportunity for a consent signature would be lost without the cooperation of the OB department.

"We pre-register all OB patients as soon as we know they are expecting," Leapaldt says. "This includes any patient who arrives for an OB ultrasound early in her pregnancy. Upon registering, we ask the patient if she intends to deliver at our hospital. If she says yes, we will pre-register her for an outpatient OB visit for a future date. We compile all registration paperwork in a colored folder [to indicate OB], send the folder to OB, and they keep the paperwork until the patient comes in."

Most OB patients make an outpatient visit or two for one reason or another, and all OB patients are instructed by their physicians to go to the OB department — bypassing admissions — when they come to the hospital, she points out. "The OB staff perform the registration process, obtains the signatures, verifies the face sheet information, and sends the necessary paperwork to admissions, where the registration is completed."

If the visit was an outpatient visit, Leapaldt adds, a new folder is compiled and sent to OB for the patient's next visit. This continues until the patient delivers, at which point the outpatient OB account is changed to an inpatient account.

"This has worked very well for out facility, and we appreciate the cooperation of the OB staff," she says. "Their willingness to perform registrations has eliminated a lot of follow-up telephone calls for consents and demographic information."

[Editor's note: To respond to Leapaldt's comments or to offer feedback on another access issue, please contact editor Lila Moore at (520) 299-8730 or at lila moore@mindspring.com.] ■

Separate discharge area promotes copay collection

Use cues to direct patients

(Editor's note: This second part of a two-part series offers tips for collecting copays at discharge.)

It's not a question of whether you should ask patients for copays, but when, say several ED reimbursement experts. Here are three strategies for doing this:

1. Guide patients toward a separate area upon discharge. Use a separate discharge area for final registration and copayments, recommends **Michael J. Williams**, president of the Abaris Group, a Walnut Creek, CA-based consulting firm specializing in emergency services. "It should be located in an area that is a natural exit from the ED," he says. "Signage can help with this."

Williams adds that verbal and visual cues to guide the patient to a discharge area are permitted under the Emergency Medical Treatment and Labor Act (EMTALA), as long as the medical screening exam is completed. He suggests giving patients discharge instructions orally, but having them pick up written instructions along with prescriptions in the discharge area.

2. Avoid EMTALA violations. EMTALA requires that there be no delays in the medical screening exam for financial reasons, but having a copay process at the end of the discharge process does not violate this, according to Williams. He recommends the following to avoid violations:

- **training and retraining all staff on EMTALA requirements annually;**
- **educating registration staff on point-of-service collection strategies and tools;**
- **use of scripting to avoid statements that might be misunderstood by the patient.**

3. Discuss copays during registration, but ask patients for payment only at discharge. At Inova Fairfax (VA) Hospital's ED, insurance information is obtained from the patient during registration, says **Melody R. McKeel**, senior operations manager for registration and financial services. If a copay is listed on the card, the registrar says: "I see your insurance requires a $50 copay. Please pay this on your way out at our discharge window, after the doctor has discharged you."

No copays are collected at the time of registration, McKeel explains. "We have the luxury of having a discharge window right at the exit of our ED, which helps us tremendously," she says. "This enables us to discuss financial issues after the patient has received treatment." At the discharge window, all demographic information is verified, including address, phone, next of kin, emergency contact, date of birth, Social Security number, and insurance information. "We make sure that everything is properly entered so a clean bill is produced," says McKeel. "The people at the discharge information are at a higher [pay grade] level than the registrars, and their focus is quality collections."

Patients are more likely to be willing to give the copay after they have received quality care and good customer service, according to **Thom Mayer**, MD, FACEP, chairman of the department of emergency medicine at Inova Fairfax Hospital. "We actually end up collecting a lot of copays on the 'back end' of the visit," he says.

The ED currently collects 70% of its copays, reports McKeel. "We are striving to get up to 85% by working with the ED staff to make sure they ask patients to stop by the discharge window," she says. There is a system in place to follow up with patients who don't stop at the window, she adds. While checking patients out at the discharge window, the staff takes the opportunity to determine if there is going to be a financial hardship for the patient, says McKeel. "We have several programs we can offer to assist the patient," she says. "If a hardship is identified, we go ahead and complete the required documents at that time."

[For more information about collecting copays at discharge, contact:

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Finding right fit for job is call center challenge

'Disciplined approach' required

While building technical infrastructure has been the core issue for hospitals and other organizations developing customer call centers, the emerging trend is a focus on the more human part of the process, suggests **Katherine Dean**, SPHR, a partner in Banks & Dean, an international professional services firm that has headquarters in Toronto.

The best technology in the world won't suffice

"if you don't have the right frontline person interfacing with the customer," adds Dean, whose firm specializes in selection and retention solutions for call centers.

Finding the "sweet spot" between productivity and delivering quality service and consistency is the challenge when it comes to staffing customer call centers, she says.

Once they're past such issues as how calls will be routed and queued, Dean suggests that patient access directors charged with developing and overseeing call centers face what can be a tougher task.

"Call centers have been created to provide consistent service at a reduced cost — more service for less," she says. "The issue is finding the people who are the right fit for that requirement, identifying them early in the recruiting process, training them, and placing them within the call center."

Motivated and trainable

In helping call centers develop a disciplined approach to recruiting and staffing, says Dean, who is based in Milwaukee, her firm considers two characteristics in potential candidates. One is the inherent trait of being motivated to work with people and help solve their problems, she adds, and the other is whether the person is "trainable" in terms of the technical skills required.

"We make sure the person has both, after determining what the client is willing to train on and what they're not," Dean notes. "We help them get clear about the entire recruiting process."

In developing the recruiting/staffing process flow, she says, the firm helps the client understand the minimum requirements for positions. "Does the access representative need two years in customer service, a medical background? If they're clear on that, the process can be automated."

Banks & Dean designs an on-line application/screen to make sure candidates meet the initial requirements, Dean explains, and for those who don't have access to a computer, there is a toll-free number with a questionnaire. "The purpose of this is to build a pool of candidates, quickly and economically, so you don't need to spend time reading a resume until [the applicants] are already qualified."

Questions are designed to determine whether the person will be comfortable in a structured environment and whether he or she has a stable job history, she says. Once candidates pass the first screen, they're asked to answer questions — again on a toll-free phone line — that allow those doing the hiring to listen for enunciation, diction, and speech clarity, Dean notes.

Also, after a successful first screen, the candidate is given a web site address where he or she completes a quality service profile, she says. This is followed by a face-to-face interview.

"Basically, you're measuring a person's talent and potential, whether or not [hiring the person] is a good investment," Dean says. If the person is hired, she adds, the criteria used in the screening process are tracked, measured, and benchmarked against the employee's performance.

If two years' experience working in a call center was one of the hiring criteria, for example, the system can track whether or not that was a valid restriction, she explains. "Because if you put in restrictions, you limit your pool; so you tie it back to performance."

The setup with each client organization depends on its needs, she says. With an integrated recruitment and career management system, for example, the company would use the system for a prescribed period of time — typically a year — and Banks & Dean would follow up to see if the system is providing the kinds of candidates it needs, she adds.

"It's their system, and they know how to use it," Dean points out. "We transfer the competencies to them and go back every year and benchmark it. It's a long-term partnering with [the company]."

Specific recommendations are made on how best to coach and train each individual, including information on who might be likely prospects for supervisory or mentoring positions, she notes.

"The job is stressful, but if you identify the right people early on, you have someone who has a much higher chance of succeeding and staying," Dean adds. "For example, the [quality service profile] identifies people who have an adequate ability to handle stress and conflict."

Because of the nature of the job — people in seats with headphones on for measured periods of time — it also is important to determine if the job candidate is comfortable in a structured environment, she says. "We bring science and measurement to the whole recruiting process."

[Editor's note: Katherine Dean can be reached at (262) 240-9400 or (888) 241-8198, or via e-mail at kdean@banksanddean.com.] ■

Study says ED visits usually nonemergent

The majority of visits to hospital emergency departments (EDs) in the United States aren't for emergencies, according to a recent study by Solucient, a health care information company with more than a million commercial and Medicare ED claims.

Solucient found that 58% of the 106 million annual visits to EDs, or nearly 62 million cases, are by patients who could have been treated in less-acute care settings. Children younger than age 17 were more likely than any other age group to use the ED for nonemergency care. Roughly 75% of all pediatric ED patients could have been seen in a setting such as a fast-track unit or urgent care facility.

The study found that nonemergent use of EDs declined steadily as patients' ages increased, with 62% of young adult patients, 46% of older adults, and 35% of senior patients using EDs for nonemergent services. ▼

Tools sought to measure quality of hospital care

The Agency for Healthcare Research and Quality (AHRQ) is looking for tools that measure patients' experience with quality of hospital care.

In line with its priority — and that of the Centers for Medicare & Medicaid Services — of establishing a universal standard, AHRQ is soliciting the submission by researchers and stakeholders of such tools, according to an announcement in the July 24, 2002, edition of the *Federal Register.*

While the AHRQ-funded Consumer Assessment of Health Plans measures consumers' experience within the health care system, it doesn't address patients' experiences within the acute care setting, the agency says. AHRQ will initiate the process of developing a public instrument by reviewing existing instruments that capture the patients' hospital experiences.

More information is available at www.ahrq.gov. ▼

Grants fund patient satisfaction studies

Press Ganey Associates, a satisfaction measurement and improvement firm based in South Bend, IN, will award five $10,000 grants over the

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Editorial Questions

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next 12 months for applied research to identify best practices for use throughout the health care field.

The grants are part of the company's continuing interest in promoting systematic and rigorous study of patient satisfaction, according to a statement by Press Ganey.

The application is open to full-time academic personnel and doctoral graduate students as well as members of the health care field with an interest in patient satisfaction research. Details on the research grants, including more about the application and evaluation process, may be obtained at www.pressganey.com. ■

Clinical trials harmed by lack of informed consent

The mention of clinical trials often triggers a silence between physician and patient, usually because neither one knows much about the subject. Nearly 80% of physicians admit they would like to know more about clinical trials so they can help their patients make an informed decision before volunteering to participate.

"Most subjects enrolled in clinical studies have a meager understanding of what they have gotten into," says **Alan Sugar**, MD, chairman, New England Institutional Review Board and professor of medicine at Boston University School of Medicine. "Informed consent has largely focused around the signed form and has not practically become the continuous process that it needs to be. As a result, a subject's misunderstandings largely go unchallenged."

Properly informing patients is not only ethically necessary, say clinical trials experts, but it also ensures better trials and data. Last year, more than 17 million people thought seriously about participating, but only a few million actually completed their trials. And even among them, many gave their consent without a thorough knowledge of the facts. Indeed, patients can be so daunted by questions and lack of information that they simply decide not to volunteer.

"There's a simple ethical mandate that you don't ordinarily do dangerous things to people without their knowledge and consent," says **Dale E. Hammerschmidt**, MD, FACP, associate professor of medicine and director of Education in Human Subjects' Protection for the University of Minnesota Medical School in Minneapolis. "From a more pragmatic perspective, a well-informed subject is likely to cooperate better with the trial and is more likely to report potential problems. The quality of the data and the safety of the trial are both enhanced when the subjects really know what's going on."

A new resource, written for doctors and clinical trial participants, can help answer some of these tough questions. Boston-based CenterWatch, the leading publisher of clinical trial news and information, now offers *Informed Consent,* a guide to the risks and benefits of volunteering for clinical trials.

Informed Consent is a step-by-step guide that begins with a history of the clinical trials industry, explores the drug development process, and how a new drug makes its way to the marketplace. It also details why people decide to participate, how to find clinical trials, how to research clinical trials and evaluate their risks, how to ensure proper informed consent, what the vulnerable populations are, and what to do when things go wrong. Cost is $16.95, and can be ordered from CenterWatch at (800) 765-9647, or by faxing (617) 856-5901. It also can be ordered through www.centerwatch.com, www.amazon.com, and www.barnesandnoble.com. ■