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Three traditional units combined to create more efficient patient care

'Filtering process' must begin immediately

Three traditional hospital units — access management, hospital information management, and case management — are being combined in an innovative project called "Trio" at ScrippsHealth in San Diego. The idea, says **Jack Duffy**, FHFMA, corporate director of patient financial services, is to start shaping decisions on how a patient's care is organized immediately, not three days later when crucial information finally has trickled down from registrar to caregiver.

"There is a filtering process that needs to begin as soon as you know a patient is coming in, so limited resources can be applied where they'll do the most good," he says. "Otherwise, you're finding out on the day a patient should clinically leave that you're clueless as to where you can send them."

Seamless coordination of the functions of those three traditional departments offers several advantages, Duffy points out. "It offers a significant opportunity to reduce the incidence of re-interviewing patients." It also helps identify key clinical indicators of future care and the insurance coverage and benefit design needed to support that care. "If you attempt to assist the physician and the family in arranging post-acute care and are not intimately involved with the patient's benefit package, you run into dead ends," Duffy says. "In the world of managed care, there is often subordinated risk. You need to know not only that the patient has a skilled nursing facility benefit, you need to know which patients have contracts with us."

"If you . . . are not intimately involved with the patient's benefit package, you run into dead ends."

Trio represents an effort "to look with 20-20 vision at any key value that originates at the point of first contact in the access process," he says. That access team member would use "push technology" to pass information along the continuum of care, he adds. "That means you don't have to ask me for an answer; I will push it to you.

"If you can't have the point-of-service information flow very nicely, the whole concept of working with physicians to enhance the care design falls apart," he says. "Redefinition of the access management department is critical to those seeking the next level of partnership with physicians."

Health information management, he says, is moving into two skill sets. "One is coding, which I think will become part of the access employee's portfolio. The other major topic for health information is chart management and completion." That has to do with quality of the medical record, archiving and retrieving the record, and distributing it along the continuum of care, Duffy says.

"In the future, this will be done in an electronic environment, so there will be significant overlap in the pre-coding of the record," he notes. "If done right, using the right mix of professionals, those coded messages will not be repeated when the medical record is abstracted and final review is done at discharge. Hospital information management will become more seamless, building the record all along the patient's stay."

There is a growing recognition at many institutions that traditional hospital administrative departments are coming closer together, Duffy says. Often, however, the partnership is not at a level where it's the driver of care management, he points out. The desired scenario is not simply writing down the diagnosis the physician dictates over the telephone, but pre-coding a chart to include medical necessity, he adds. "It is understanding [whether] the physician's orders meet the test of medical necessity and feeding them, along with a profile of the patient's benefits, to the care management team."

Part of making Trio work, Duffy explains, is acknowledging and celebrating the different skill sets brought to the table by the three departments. "That's so we won't try to blend [staff] into something they're not comfortable with. We will leverage information, take a person's traditional strengths, and make them available at the right time. I think it will be a very deliberate type of sale. You can create an environment resistant to change if this is not done carefully."

Part of that sale will be letting the teams feel they have a significant influence on the process, he adds. "We will let them design their future within our vision. We know we have to spend several days over the next couple of months in retreat."

At these retreats, managers and key support staff in the different silos come together as a group to get input on the new design, he says. "All roles will be modified. Some [managers] will be reassigned. Some will get additional responsibility for enterprise activity.

"There will be some specialization across the enterprise," he adds. "Along with their day-to-day activities, they will have an enterprise portfolio. There might be an electronic record storage specialist. People will get tags like that as their interest and talents lead to some of these activities." ■

Realignment shifts from hospital to corporation

Seven product lines redesigned

ScrippsHealth has realigned its finance department to match the health system's new emphasis on product-line systems of excellence, says **Jack Duffy,** FHFMA, corporate director of patient financial services.

"We've moved from the traditional CFO to different people in charge of functions for the enterprise," Duffy says. "They don't think of themselves as working for a specific hospital unit."

Under the systems of excellence, a financial executive and a group of analysts work with an administrative person and a physician leader to understand and redesign each of seven "product lines," he says. These are: neurology, orthopedics, woman and child, primary care, critical care, psychiatry, and hospital-based physicians (emergency department, pathology, radiology).

He says the financial executives and physicians work together to develop, for example, ways to reduce the number of supply vendors and which

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blend of acute and subacute care yields the best outcomes and the best economic footprint.

ScrippsHealth began with a chief financial officer (CFO) at each of six hospitals. Those CFOs were given new titles — directors of finance — and eventually were replaced by two regional directors of finance.

"Now we've eliminated all direct financial management and reassigned those resources into two areas," he explains. "One [financial team] supports the expense functions, and the tool used to do that is called systems of excellence. The second alignment is around managing revenue.

"You have to get a shared vision. You're talking about not only consolidation of ownership, but also centralization of services."

Trio comes under that, as does a technical group that supports return on investment." **(See related story at right.)**

The reorganization has two drivers, Duffy notes. "One is to eliminate variance between hospitals that have come together to enterprise. If you support multiple forms, it's more expensive, and you can't move staff around when you have vacancies."

The second driver is to allow capital allocation to occur at the enterprise level, he adds. "The need of a product line will supersede the need of an individual facility. It's not based on traditional capital allocation."

Easing concerns

It took about a month, he says, to walk hospital administrators in Scripps' multiple settings through the rationale for the redesign. They were concerned about the allocation of resources, about where their day-to-day support would come from, he adds. "How do they get it handled when Dr. Jones wants a new machine, or when a patient has a complaint?

"When you suggest more corporate influence in an enterprise, that can be translated into less control if you're a hospital administrator in an enterprise system," Duffy says. "You have to sell it. You have to get a shared vision. You're talking about not only consolidation of ownership, but also centralization of services." ■

Will AMs rule when departments combine?

Health care organizations looking to combine other departments with access management may be seeking a single professional manager to oversee the new creation, says **Jack Duffy**, FHFMA, corporate director of patient financial services at ScrippsHealth in San Diego.

For health systems like ScrippsHealth, which is combining access with health information management and case management, he says, the first question might be, "Can we recruit a manager with enough range to supervise the three departments that have become one?"

A subsequent question might be whether an access manager will be the professional chosen for that multifaceted position, Duffy points out. "Are traditional access managers strong enough to be candidates for these jobs, or will the nurse or the RRA [registered records administrator] be the one? I don't know. Maybe each organization will make up its own mind."

Certification a likely issue

One of the issues in making that determination is likely to be certification, he says. "Historically, access employees have not been certified. Hospital information management employees have traditionally been required by the Joint Commission on Accreditation of Healthcare Organizations to have the RRA or another certification. And case management is dominated by registered nurses. I predict access representatives or associates [eventually] will be certified, but I'm not sure what year it will happen. It's just a question of when the Office of the Inspector General and the Health Care Financing Administration get to it."

Because few access managers have taken advantage of certification opportunities, they often have been classified as generalists in the hospital hierarchy, he adds. If more area management possibilities open up, Duffy says, access managers should look at continuing education in terms of what will help support them as candidates for these multidepartment positions. "If an RRA or a master's in nursing takes the lead, an access manager may not compete successfully. But a dually qualified access manager could be an attractive candidate for a key position." ■

Upending revenue cycle first step toward success

Mention combining departments and reorganizing functions, and health care consultant **Bobette Gustafson** quickly informs you of a key philosophy of her company: "We never talk about who should do anything until after the process is defined."

The plan by ScrippsHealth in San Diego to bring together patient access services, health care information management, and case management into one department suggests the following question, she says: "What's the process that seems to demand this?"

"That process is the revenue cycle turned upside down," explains Gustafson, president of Gustafson & Associates Inc., a health care management consulting firm based in Port Washington, WI.

In today's managed care environment, a provider must have completed several functions before committing to schedule patients without life-threatening problems for future service, she points out. "That includes gathering comprehensive data sets, searching for and resolving managed care requirements, and educating patients about insurance. Couple that with a demanding customer who traditionally has been upset by all the multiple contacts and repeated requests for the same information."

The only way to upend the proccess adequately while providing customer service is by consolidation, or at least coordination, of the activities being combined by ScrippsHealth, Gustafson says. "That doesn't necessarily imply an organizational change. I don't think it matters who reports to whom or where functions are located, because reporting relationships don't make people do what they're supposed to do. You just have to bring the functions into coordination."

The ultimate effect of such a re-engineering must be that the people responsible for the upfront activities become the "owners" of those activities, she says. "In a traditional arrangement, upfront staff do the best they can, and the business office cleans up after them. There are so many employees involved in editing and cleaning up. In the new model, that goes away. The traditional back-end business office becomes very small. With providers where we have facilitated re-engineering efforts, typically 40% to 60% of the FTEs [full-time equivalents] need to move out of the back end into the upfront activities."

It's also crucial to recognize, she points out, that the various departments or functions are "interlaterally dependent. All are absolute stakeholders — none can function without the other.

As health care providers move away from the inpatient setting and serve more and more outpatients, they are increasingly bound by managed care requirements and the changing nature of contracts, she adds. "Part and parcel of this is case management.

"The only way to handle the volume plus the constant change is through technology," explains Gustafson. "We have added so many systems to try and support, with few solutions from one vendor. Information systems becomes almost the central core in trying to integrate and interface all these systems." ■

GUEST COLUMN

Wireless technologies offer new care options

Here's chance to move action closer to patients

By **Matt Hisle**, PE
Superior Consultant Holdings Corp.
Southfield, MI

(Editor's note: This is the first of two articles exploring the biggest gains in wireless technology.)

In the olden days, health care came to the patients. Physicians arrived at the patients' doorsteps, black bags in hand, ready to provide care whenever needed. Physicians accompanied patients to the hospital and admitted them directly — all without burdening patients to fill out forms, prove insurance coverage, or discuss their health conditions in detail.

While this approach to medicine now exists only in old television shows, the public recalls it with fondness as the Golden Age of medicine. Today, the patient comes to the care, whether it be a physician, nurse practitioner, ambulatory clinic, or hospital. Upon arrival, the patient sets out on a

tortuous process, often moving to various locations before actually receiving treatment.

Wireless technologies, combined with new information technology and new ways of working, offer hope for reversing the trend and improving the patient's view of the process and the health care environment. These technologies also promise to speed response to critical care needs and improve medical staff productivity. Rapid improvements in functionality, combined with dramatic price decreases, make wireless communications systems a feasible alternative.

1. Wireless data communications systems

Most hospitals exploring this area focus on using wireless communications systems to transmit and receive information as data, text, or images. As more information becomes integrated into electronic medical records, on-line insurance databases, and telemedicine systems, critical data about each patient are generated, tracked, and used on-line in real time.

Wireless data systems allow the user to break the ties of geography and create and use this information anytime, anywhere. No longer must terminals be situated behind desks or only in physicians' offices, clinics, or hospitals. With the proper networking and security, any information in any information technology system in the hospital can be available to the caregiver, regardless of physical location.

There are two major classes of systems: One provides services for access to networks and information within a physical building (local area networks), and the other provides access across wide geographical areas, such as cities (wide area networks).

2. Local area networks

Access to local area networks (LANs) at reasonably high speeds has only recently become technically and economically possible. Imagine a traditional connection of a PC to a LAN in a hospital. Now break the wire connecting the PC to the wall, convert the PC to a more ergonomic, portable device, and add an antenna. Finally, carry the new device anywhere. This is the essence of the wireless LAN. Here's how it can be used in several situations:

- **Registration/admitting:** Use a portable laptop or workslate to interview, triage, verify insurance, review medical history, and schedule a patient, all at the patient's preferred physical location.
- **Patient charting:** With the rapid advances in electronic medical records, electronic entry and access can be accomplished by anyone properly equipped. Wireless systems allow this data entry and access to occur anywhere, even in transit. For emergency patients, this means data can be entered and accessed simultaneously with the provision of care, regardless of location. For recovering patients, nurses can spend more time at the bedside and less time at the computer desk.
- **Real-time lab results:** Why wait until someone sits at a terminal and accesses a status screen? Using push technology and terminals as simple as two-way alphanumeric pagers, physicians and other caregivers can be updated with test results as soon as they are completed, without having to lift a finger. When seconds count, this can make a difference.
- **Testing on the run:** New tools for testing, such as blood analyzers, have become more compact and portable than ever. When linked with wireless systems, handheld labs can report results instantaneously for redistribution to all concerned parties.
- **Reconfiguration on the fly:** Need to redesign your admissions area to handle different or increased patient flow or new operational methodologies? No need to wait for LAN cabling to be installed — just relocate the wireless connected devices, and you are back in business.

3. Wide area networks

For some patients, the access process starts long before they reach the door of the hospital. In order to bring care to these patients, our networks must be able to reach outside the hospital walls to support patients and caregivers regardless of where they might be.

Wide area network systems are in their infancy. Performance is restricted, and coverage is not 100% complete. However, the rise of digital cellular systems, personal communications service systems, and other digital-oriented radio systems in recent years has created an infrastructure that provides for acceptable speeds of information transmission, regardless of location, within most major metropolitan areas.

Real advances are being made through development of improved information terminals. Ultralightweight laptops, personal digital assistants such as Palm-Pilot, and Windows CE palmtop systems have made information entry and access ergonomically acceptable. Nonkeyboard- information entry techniques such as voice recognition

will make these systems even more feasible. So what does our well-dressed roaming provider do with this technology? Consider these uses:

• **Emergency services:** Using palmtops and a wireless-based data network, emergency medical crews can enter patient data, access medical records, and even admit patients while still providing care at the scene or while under transport. When the patient arrives, the admitting process is complete, the emergency department team is completely informed of all relevant medical data, and care transfers seamlessly to the in-house staff.

• **Physician notification:** Depending on the receiving device, off-premises physicians can receive constant updates on the progress of their patients. These can include test results, charting updates, and even updated imaging and patient monitoring data. Thus, physicians are never out of touch, whether they're at the office, another patient location, or a basketball game.

4. Wireless voice communications systems

Although wireless phones have been in use for years in the homes as car phones and handhelds, their use is still maturing. New technology available from every major telephone system vendor has shrunk the business phone to cell phone size and made it portable. Now, miniature portable phones can be taken anywhere within a hospital.

These allow users to receive calls on their main number, transfer, access voice mail, manage multiple calls, and even see who is calling before answering. Anything that can be done with a desk phone can be done with a portable. High voice quality can be maintained, and there are no usage charges for phones dedicated to the local PBX.

This capability frees the physician, the nurse, the lab specialist and even the porters from the tyranny of the telephone. One can be responsive to inbound callers, even while performing the key services that patients require. In a real-life example, wireless phones were critical to the implementation of a successful "quiet hospital" program targeted to the neonatal ward.

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Career Paths

Hospital's new venture is step up career ladder

Access skills a fit for practice management

Her hospital's venture into management of a medical practice has presented a new career opportunity for **Susan Pouliot**, RN, MA, the longtime director of patient registration for Parrish Medical Center in Titusville, FL.

The new position, director of Titusville Family Practice, appears almost tailor-made for Pouliot, who took steps during her 14-year tenure as patient registration director to prepare for career advancement. These achievements stand out when she considers the qualifications that made her a strong candidate for the job:

• a master's degree in computer resource and information management and a second master's in health service management, which she'll complete in May;

• experience as a physician liaison, including responsibility for a quarterly office staff luncheon;

• active participation in preparing for surveys by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

• familiarity with the hospital's computer system.

Under Parrish Medical Center's arrangement with Titusville Family Practice, the hospital will not own the practice, just manage it, Pouliot says. The physicians will be employees of the hospital, and so will their staffs. The plan is that eventually the practice will grow, with other physicians coming on board, she adds, but for now the focus is on improving the existing practice.

"Right now, they're very busy, but somehow the volumes are not that high," Pouliot says. "We'll try to increase patient volume. Two physicians are leaving, so we'll be recruiting other physicians to replace them, as well as adding two nurse practitioners."

The hospital will use a project engineer to look at the practice's process flow, "to see if we can make the process easier and faster," an effort

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Pouliot also will be involved in, she adds.

Although the hospital's contract with the physician practice is effective Feb. 1, Pouliot assumed her position in mid-December. Her immediate challenge, she says, was twofold: to get the computer system up and running and to bring office staff up to par with the hospital's benefits and pay scales.

Parrish Medical Center will buy the physician practice module for Meditech, its computer system, and bring Titusville Family Practice on-line, she says. "Once we get that going in their office, we will offer it to the other physicians we have on staff." The physician practice module will allow physicians more leeway and flexibility in accessing hospital data, she notes. "They will be able to schedule their own outpatient testing, get statistics, and so forth."

Using wireless technology, Parrish will connect the medical practice to its hospital information system network, Pouliot adds, and physicians likely will be able to use the system's transcription capability. "We're now transcribing in Microsoft Word, which is converted into our patient care inquiry system. We're thinking of tying in [the practice physicians], so if a patient of theirs comes into the emergency department [ED], the ED physician knows what happened on the patient's last office visit." If the patient says, for example, that a pink pill was prescribed but does not know the name of the medication, the ED physician will be able to look and see exactly what the medication was, she notes.

Another focus will be on evaluating the medical practice's antiquated telephone system, which has caused patients to experience long hold times and difficulty getting through to the office, she says.

Along with the demands of technology, Pouliot points out, she will face a human resources issue with the office staff. "Employees are feeling insecure because things are changing. They're used to being in a small practice, and now they're becoming part of a larger facility. One of the big challenges is to keep up their morale."

In her new position, Pouliot will learn more about the office staff's needs, she says, allowing her to become an even more effective physician-hospital liaison. "In patient registration, we're always complaining about the physician offices, saying, 'Why can't they do this and that?' Now I will see why they can't do this and that."

In addition to her continuing oversight of the office staff luncheon, she will conduct coding workshops for office staff and keep them abreast of new Medicare requirements, Pouliot says. "I'll have two offices, one at the physicians' office and one at the hospital. They want me to know what's going on in both places."

Her previous position will be "re-engineered," she says, but a replacement will be sought and the job will remain at the director level. "The complaints were unbelievable when I came in 14 years ago, and now there are virtually no complaints. They don't want to go backwards. The CEO is adamant about that."

Her new job can lead to more opportunity for career advancement, she says. "There are possibilities of growth as more and more practices come on. I was looking for something challenging, and I certainly have gotten it." ■

Solve 'people puzzle' to cope with change

'If you don't connect, you've lost'

For health care managers going through organizational change and staffing challenges, one of the keys to survival is "building your people puzzle," says **Sheryl Nicholson,** president of Strategic Survival in Brandon, FL.

In an environment that requires doing more with less, it's crucial to connect all the pieces of the puzzle, adds Nicholson, who describes herself as a "people-productivity" expert. "We can no longer leave one piece on the table and say, 'personality conflict.' We have to move that [person] to a different part of the puzzle. If you don't connect, you've lost, and the organization loses because you don't get the full value of that puzzle piece."

Managers, or "coaches" in Nicholson's terminology, often are told they're supposed to motivate staff, which she says is impossible. "You cannot motivate people — they motivate themselves. So it's your responsibility to create a self-motivating environment."

To do that, Nicholson says, managers must do an assessment of their employees, determining whether they fit a "D," "S," "I," or "C" pattern. She explains the patterns as follows:

• **"D" is for "driver."** These people are motivated by change, challenge, and control. If you want to implement something different, give it to them. They like quick, short conversations, are very direct, and move quickly. This is the physician who asks for a patient's record and says, "Why wasn't it here two minutes ago?"

• **"S" is for "steady" and "supportive."** These are the natural caregivers, who move more slowly through life and hate change. "S" types are often nurses or social workers. They show up every day, never call in sick, and are sometimes put in management positions because they're so stable and consistent.

• **"I" is for "influencers."** These are the employees who thrive on recognition and praise and have to be near people to influence or be influenced by. An "I" is the person you don't ask on Monday, "How was your weekend?" for fear of hearing more than you want to know. They're important to the puzzle because they have a naturally positive attitude.

• **"C" is for "cautious" and "conservative."** These are the employees who'd rather write a memo than talk to you. They're probably thinking the whole time you're talking.

Taught to flex style

Nicholson teaches her clients "chameleon living," or how to "flex" their style to better connect with other parts of the people puzzle. The bad news about those with the "D" pattern is that they think everyone should adapt to them.

An "S" typically takes it personally when an authority figure arrives in a foul mood, but that response is not the appropriate one, Nicholson points out. "Modify your behavior so that it's like water off a duck's back." If, for example, a physician says, 'I need this at 2,' don't give a long, involved answer about everything else you have to do, she advises. "All the "D" wants to hear is a short, quick response."

When there's a "misfit" in the department, that individual often is blamed, she says, but it's usually the manager's fault. "The coach hasn't gone deep enough to determine what that person's gifts are. They've taken, for example, someone who's a good communicator, naturally positive, and put that person in the back working with files."

A question she often puts to the managers in her audiences, Nicholson says, is, "When was the last time you interviewed your staff?" She says she interviews her own staff twice a year to find out what they're excited about and what challenges have occurred. "We just assume our people know how to do the job," she adds. "We throw new things at them and ask stupid questions like, 'Are you OK with this?' They say, 'Yes, boss,' and we go away. A good coach checks in."

To help build your own people puzzle and enhance your survival skills, Nicholson recommends belonging to at least three associations:

• a "who's who" of the health care industry, which provides strong role models for professional growth;

• an organization of your peers, which enables you to keep up with trends and find a job if yours ends;

• a community organization, which allows you to fulfill your humanitarian obligations.

One of the messages she shares with her clients is not to panic when change occurs in their organizations, Nicholson says. "People get fearful, wondering what will happen with their job." Instead, she recommends looking for the latent "gifts" that sometimes appear when there is a crisis.

"One of my philosophies is that if you breathe air, you bring a gift to the life party," Nicholson adds. "Become a gift investigator. Get excited about every opportunity when a person crosses your path. See that life party as a whole room full of gifts, and you get to unwrap them," she says. "If I hadn't learned to do that, I would have hated to be on the road so much."

(*Editor's note: Sheryl Nicholson contributed to the books* Chocolate for the Woman's Soul, Chicken Soup for the Woman's Soul, *and* Chicken Soup for the Mother's Soul. *She has written two self-published books,* Working Women Are Working Wonders *and* Listen Up, Don't Talk Down. *Nicholson spoke recently at the annual education conference and exposition of the Florida Association of Healthcare Access Management.)* ■

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Hospitals seek balance in care of homeless patients

LOS longer than for indigent with homes

While the problem of caring for homeless patients might not be as pressing in rural areas as in their urban counterparts, hospitals throughout the country must come to grips with the challenges these patients pose to the bottom line, experts say.

The bottom line, according to new research data, shows that homeless patients stay longer and cost hospitals more than indigent patients with homes. The challenge is to create a balance between the cold facts of hospital finances and providing the best care possible for the patient.

A recent study by the New York City Health and Hospitals Corporation of almost 19,000 homeless patients admitted to New York-area hospitals between 1992 and 1993 compared the hospital charges and expenses for those patients with 384,000 low-income patients with homes.[1]

The findings were not promising: Homeless patients stayed an average of 36% longer than indigent patients with homes. What's more, the extra length of stay alone cost the hospital system an average of $2,414 per homeless patient. Add that to the heavy burden of absorbing the cost of indigent care, and the amount is much larger. The major reasons for the extended length of stay, the researchers say, are legal mandates requiring homeless patients suffering from mental illness to be discharged into a supportive environment.

A shortage of available supportive housing and psychiatric beds means this wait could be months long. Severe overcrowding in city shelters and lack of low-income housing means many other homeless patients are kept in a hospital bed until shelter space becomes available, the report continues.

While federal regulations create bureaucratic bed nightmares that seem hopeless, hospitals can take action to curb the problem. Several public hospital systems, for example, are tackling it aggressively. Public hospitals face more challenges than their private counterparts. They are charged with providing health care to the community at large and are overburdened with the costs of caring for the homeless. But by taking the step of developing health outreach programs, an attempt is made to head off illnesses that land these patients in a hospital bed in the first place.

In addition to the costs of extended inpatient stays, many caregivers say, public institutions have an ethical obligation to ensure unbiased access to basic health care. What's more, the access should be early, not after homeless patients are in need of hospitalization.

"As the public hospital for the county, we are charged with ensuring access to health care to the community as a whole," says **Susan Spaulding**, MD, director of the Homeless Outreach Medical Services program (HOMES) at the Parkland Health and Hospital System in Dallas.

A few years ago, Parkland began an effort to improve access to primary care and preventive medicine by opening several small community-oriented primary care clinics (COPCs) throughout the city. The HOMES program and COPCs are funded jointly by Parkland and the city of Dallas.

"The concept is that by bringing primary care into the neighborhoods where people live, it enables the public to easily access the health system and enables us to treat health problems before they become so severe that they require hospitalization or other, more intensive health care resources," explains Spaulding.

Mobility makes the difference

The HOMES program is in essence a COPC for the homeless population of Dallas, she says. "It is basically the same thing, it is just that this one is mobile."

Staffed with a full-time internist and a full-time pediatrician, a clinical psychologist, registered dietitian, three nurse practitioners, three RNs, four social workers, an administrative coordinator, and three health care assistants, the HOMES program operates as a six-site health clinic and also has two 40-foot-long mobile medical vans.

HOMES holds 30 clinics a week at 18 different locations throughout Dallas. Open for three-hour sessions on Monday afternoons, Tuesday, Wednesday, and Thursday evenings, and Friday mornings, the clinics offer well-child checkups, immunizations, acute care, referrals to other programs and social services, adult health maintenance evaluations, STD and HIV screening, acute and chronic disease clinics, and a diabetes education program.

The city started a health program for the homeless about 11 years ago, she says. Originally, the program consisted a nurse practitioner who

visited the city's shelters to provide basic medical care and make referrals to the hospital.

Seven years ago, Parkland took over administration of the program, expanding it to the current level. Now it is one of the system's COPCs, although the only mobile one, Spaulding says.

Physicians in the HOMES program now can do lab work, such as blood testing, for homeless patients. They have a class D pharmacy on both vans, and the physicians can make referrals to specialists at Parkland's hospital. "With the move to the COPCs, this was another effort at getting out into the community," Spaulding says.

The hospital system doesn't keep data on which patients are homeless, so there is no accurate way to gauge the program's financial impact, but Spaulding says the efforts the HOMES staff makes at preventive care result in fewer primary care visits to the hospital's emergency department (ED). "The cost of a visit to the HOMES site is much less than the cost of an average ED visit."

The project has a budget of $1.5 million that is split between city funds and Parkland's operating funds, she says. The hospital system absorbs most of the cost of the care, but she notes that in the past few years, the hospital has been able to lessen its dependence on the Dallas tax base, becoming largely self-sufficient. "That is always a challenge for any public hospital system."

Cooperative agreements an option

Some hospital systems, however, have developed arrangements with existing homeless health programs, which take a slightly different approach to solving the problem of providing care to the homeless. In cooperative agreements, a hospital system provides funds and administrative and clinical support to an organization already familiar with the homeless population and set up to handle that population's specific needs.

The Health Care Center for the Homeless (HCCH) in Orlando, FL, for example, operates a primary health care clinic, dental clinic, vision clinic, wilderness outreach program, and tuberculosis shelter on an annual budget of about $500,000. HCCH receives about $750,000 in support and in-kind services from three area hospitals: Florida Hospital, Orlando Regional Health Care System, and Central Florida Health Care System. "We also have specialists throughout the community who give us two procedures a year, and we make referrals to them," says **Paul McGlone**, president of HCCH.

When patients need surgery or hospital admission, the hospitals take the case on a rotating basis. The center has more than 9,300 patient visits per year to its primary care clinic at a cost of about $361,000, or $38 per patient.

By helping homeless people enter the health care system at a primary health care level, the center has been able to treat acute medical problems before they require a hospital admission, says McGlone. By helping them manage chronic conditions such as diabetes and hypertension, the center also has helped reduce visits to area emergency departments, he notes.

Team includes 77 volunteer physicians

The center has a full-time clinical staff of one physician, one nurse practitioner, and a paid dental hygienist to manage the cases in the dental clinic. It is heavily dependent on the specialists and other health professionals who volunteer their services, he says. Primary care clinic volunteers include 43 primary care physicians, five advanced registered nurse practitioners, 22 nurses, and seven front desk (intake) personnel. There are 77 volunteer physicians who provide specialty secondary care, he adds. "We have one retired physician who comes in and works evenings in our primary care clinic 2½ days a week."

A retired dentist also comes in and spends one evening a week seeing patients in the dental clinic, he says. "I think that this is evidence of what can happen when you have everyone working together. You hear a lot about medical centers and hospitals and how competitive they are, but this is an example of [different systems] coming together to work toward a solution."

Reference

1. Salit SA, Kuhn EM, Hartz AJ, et al. Hospitalization costs associated with homelessness in New York City. *N Engl J Med* 1998; 338:1,734-1,740. ■

Need More Information?

- **Paul McGlone**, Health Care Center for the Homeless, 11 North Parramore Ave., Orlando, FL 32801.
- **Susan Spaulding**, MD, Parkland Health and Hospital System, 5201 Harry Hines Blvd., Dallas, TX 75235.

NEWS BRIEFS

Model plan shows how to comply with payment regs

The American Health Information Management Association (AHIMA) in Chicago has a new model compliance plan designed to help health care organizations comply with the mix of laws, regulations, and policies that govern payment for health care services.

The model, which covers compliance issues from the health information management (HIM) perspective, identifies and explains the key elements compliance plans should contain, such as:

- a mission;
- code of conduct;
- methods of oversight;
- compliance policies and procedures;
- plans for training and education;
- procedures for enforcement;
- methods of solving and correcting problems that may arise.

Desirable skills listed

In addition, the model includes a description of the skills professionals who manage compliance programs should have. At the top of the list is extensive knowledge of what constitutes accurate clinical documentation in all types of health care settings.

Other characteristics include knowledge of billing and coding practices; the conventions, rules, and guidelines for multiple classification systems; and knowledge of reimbursement systems. According to the model, more generic skills — such as strong leadership, managerial, communication, presentation, and analytical skills — are important as well.

The model also includes a sample job description for an "HIM compliance specialist" and several sample audit tools and forms.

"Health Information Management Compliance: A Model Program for Healthcare Organizations" can be ordered by calling (800) 335-5535. The cost is $32 for AHIMA members and $40 for nonmembers. ▼

The devil's in the details

On Oct. 21, 1998, President Clinton signed the Omnibus Spending Bill into law. The measure included spending bills for these federal departments: Labor, Health and Human Services (HHS), and Education; Agriculture; Commerce, Justice, State; District of Columbia; Foreign Operations; Interior; Treasury and Postal Service; and Transportation. Here are details of the bill, as analyzed by the Joint Healthcare Information Technology Alliance, a recently established think tank.

• Prohibits the HHS secretary from promulgating or adopting standards providing for a unique health identifier (UHI) without first obtaining explicit congressional approval. Thus, two years after directing the secretary to create such a unique identifier, Congress has indicated it intends to review the issue again, and many observers anticipate the introduction of legislation next year that

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would repeal this provision of the Health Insurance Portability and Accountability Act of 1996. Earlier, the Clinton administration announced that no UHI would be implemented until comprehensive privacy legislation is passed by Congress.

• Includes substantial across-the-board funding for HHS (major increases for AIDS treatment, disease prevention, and biomedical research); hastens phase-in of full tax-deductibility of health insurance for the self-employed; and provides a fix for Medicare's home health interim payment system.

• Includes the Internet Tax Freedom Act, which establishes a moratorium that no state or political subdivision may impose any of the following taxes from Oct. 1, 1998, and extending for three years from the date of enactment on Oct. 21: taxes on Internet access, unless such tax was generally imposed and actually enforced before Oct. 1, 1998; and multiple or discriminatory taxes on electronic commerce.

• Establishes an Advisory Commission on Electronic Commerce that will conduct a study of international, federal, state, and local taxation and tariff treatment of transactions using the Internet and a study of Internet access and other comparable intrastate, interstate, or international sales activities. The commission will report to Congress within 18 months reflecting the results of the study, including any recommendations for legislation.

• Provides $45 million for the Health Care Financing Administration transition to a single Part A and Part B processing system and year 2000 conversion requirements of external contractor systems.

• Provides $1 million for the National Bipartisan Commission on the Future of Medicare for fiscal year 1999. ▼

HIMSS conference to be held in Atlanta

"Discover the Synergy," the 1999 Healthcare Information and Management Systems Society Conference & Exposition will be held Feb. 21-25 at the Georgia World Congress Center in Atlanta. More than 150 educational sessions are scheduled, with topics including year 2000 compliance, computer-based patient records, and the Internet and Intranet.

For details, call (877) 446-7799 or visit the organization's Web site at www.himss.org. ■