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'Disjointed' training, authorization errors targeted in new education push

Compliance concerns spark effort; staff morale gets boost

Error rates are down and staff confidence is up at Jackson Memorial Hospital in Miami, thanks to the institution of a training and development group within patient access services, says **Gil Amara**, CHAM, assistant administrator for patient access services.

Responding to the compliance concerns dominating today's health care environment, Amara designated a supervisor and two trainers to provide comprehensive, uniform training of all new patient access employees. In addition, the new education personnel conduct regular inservices for access employees and get the word out to other departments on what patient access is all about, he adds. "Before, each individual supervisor trained each individual employee, and we also had lead employees who helped train," Amara says. "We found that everything was disjointed, not consistent, and that there was no continuity. Emphasis was placed differently by different people."

Access representatives were producing accounts with numerous errors and omissions, which caused a domino effect when those accounts reached patient accounting, adds **Brian Palmer**, coordinator of the patient

access services training and development group. Because the accounts are routed according to plan code — whether it be for Medicare, Blue Cross/Blue Shield, or another payer — the mistakes could cause long delays in payment or even reimbursement denials, he notes.

Documentation was a big issue, Palmer points out. For example, an access representative might be on the telephone for 45 minutes, waiting in vain for an authorization from an insurance company. If the employee doesn't follow the correct protocol by documenting the unsuccessful attempt, explains Palmer, it could appear as though he or she was not doing the job. "We also had to have a continuum of effort," he adds. "If an employee worked 7 a.m. to 3 p.m. and was not able to get an authorization number, it was the responsibility of that rep to give the account to the lead worker on the shift and make

"The good part is that as people become more and more educated, they're doing the job better."

Inservices spur training effort

As part of the new patient access services education program at Jackson Memorial Hospital in Miami, the training staff prepared information packets on 10 key topics, says **Brian Palmer**, coordinator of the patient access services training and development group.

Those packets form the basis for inservices held regularly for the department's 120 employees. Topics include:

- charity care;
- package pricing;
- Medicare;
- Medicaid;
- completing forms for admission;
- advance directives;
- accident report requirements;
- how access efforts impact the UB-92 form;
- plan codes and financial classes;
- entrance program (for illegal aliens).

The training effort, begun in June 1997, has paid off in several ways, Palmer says. Different employees no longer give different answers to the same access question, he notes. "We're speaking the same language."

In addition, morale has improved, and employees are more likely to seek help when they're not up to speed on a procedure, he says. "Before, employees who had been here five or six years felt hesitant to go to a supervisor with a problem. They were afraid the reaction would be, 'You should know this by now.'"

Palmer and the trainers, however, serve as "neutral" points of reference, he says. "We are not judgmental. We just give them the material again and say, 'This is the way it should be done.'

"We also feel we have better communication [among employees and supervisors] overall," he adds. "There are a lot of concerns and questions being heard and solutions implemented."

The training and development group's major mission is to "re-inservice and retrain because information is changing all the time," he says. "We also want to create and develop a new inservice for our team leaders, who are called lead workers." ■

sure it was passed along." That often did not happen in a timely manner, he says.

With the more consolidated, organized training effort, "we're seeing a drop in error rates with the admission package," Amara says. "We now have employees who feel they are more competent in what we have to do and are more comfortable because they know how to access information."

At Jackson Memorial, there are several computer systems that incorporate billing aspects, and "they don't all talk to each other," Amara points out. "We established a procedure for accessing authorization information in several locations so it could be looked for enterprise-wide." Reinforcing that procedure in staff inservices has caused the number of errors in obtaining authorization at the time of billing to drop dramatically, Amara says.

When the training program started in June 1997, the department had a 51% error rate on all accounts, Palmer notes. After six months, that figure fell to 32%.

Offsite staff get trained, too

Inservices address Medicare and secondary payer forms and managed care procedures, among other topics (see related story at left), Amara says. "It re-emphasizes what employees have already learned, because many things change in the course of a year. There are pieces of paper, e-mail, staff meetings [that disseminate information], and we want to tie that together."

The latest training emphasis, he says, is on bringing staff at Jackson Memorial's offsite registration areas into uniformity with procedures at the main campus. One procedure being targeted is the classification of a patient's indigence rating.

"Because we are the county hospital, all the indigent [people] in Miami and Dade County can access our services," Amara says. "We go through their financial information and, based on criteria given us by the Miami/Dade County ordinance, classify their indigence level. We're taking that concept and making sure it's done uniformly throughout the whole system. We're beginning to audit those [off-campus] sites."

COMING IN FUTURE MONTHS

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■ Health system realigns access positions

■ Overseeing a successful computer installation

■ How the Patient Bill of Rights affects admitters

■ Patient-focused care in the real world

In addition to the training sessions for patient access staff, the department's trainers give information overviews to new case managers, billing and collection employees, and physicians' office staffs, Amara says. "We usually set these [overviews] up on a semiannual basis, and [the target audience] depends on what the need is," he adds. If more case managers are being hired, for example, a session will be scheduled to educate them on access issues.

Regular luncheons are held with the office staffs of the University of Miami School of Medicine's physicians, who admit to Jackson Memorial, he says. "We go over who we are, what we do, and what they do. We try to break [the number of participants] into three smaller groups to make it more manageable."

To create the Patient Access Services Training and Development Group, Amara moved full-time equivalents from less critical positions. Among other changes, a night supervisor position was shifted to the day schedule.

"Sometimes you have to make a sacrifice in one place to make progress in another," he says. "It seems to be having a positive impact. Everyone is on the same page with procedures and policies. The good part is that as people become more and more educated, they're doing the job better. Because of that, my goal is that we don't need additional people to do this [training] function."

Plans call for expanding the training group, he adds. "We're looking to add an off-site coordinator and a third trainer." ■

New reporting structure 'warmer, friendlier'

Blend of patient care, fiscal savvy cited

As part of its "Patient First" performance plan for world-class customer service and enhanced marketing initiatives, the patient access services department at Miami's Jackson Memorial Hospital now reports to the senior vice president of patient care, says **Gil Amara**, CHAM, assistant administrator for patient access services.

In July 1997, soon after patient access services instituted its own training group (**see related story, p. 25**), the department left its traditional niche in the hospital's financial hierarchy to become part of the patient care division, he adds.

Although such a move might not work for every access department, he stresses, it was the right decision for Jackson Memorial for several reasons. "We had concerns having to do with marketing our patient relations side," he says. "We wanted to come across warmer and friendlier, with a high level of patient satisfaction with our service. Reporting to the senior vice president of patient care means more options are available. Between the two of us, we are accomplishing that goal."

Division is a natural fit

With its focus on patient needs and concerns, the patient care division is a natural fit for a more customer-oriented access department, he adds.

The arrangement works, Amara says, because of his financial and patient access background and because his new boss, as chief nurse, is fiscally oriented yet concerned about patient satisfaction. It might not work as well, he cautions, with a patient access director who is weak in patient satisfaction or a nursing director who lacks expertise in financial issues.

Previously, Amara reported to the administrator of patient financial services, who reported to the director of finance, who reported to the chief financial officer. Now he reports directly to the senior vice president for patient care. "Our executive staff and consultants were looking to remove the layers, to have direct access to the top to get things done, get things expedited."

Since the reorganization, he notes, Jackson Memorial has refurbished all of its admission offices on the main campus, which has made patients and employees more comfortable. "It has added to the professional image we want to exhibit to our clientele. We have begun to see an increase not only in our patient satisfaction indicators, but with our 'internal' customers as well."

In August 1998, the department implemented a new computer local access network that serves as an important communication tool. It allows Amara, his supervisors, and support staff to be in constant communication through e-mail and facilitates task and project coordination.

The innovation allows these 11 players to share schedules, ideas, and concerns that affect all the registration areas, he adds. "It also allows us to access the server, where current files and projects are archived, so that we have instantaneous updates in content and status." ■

Precert staff don't take 'no' for an answer

'We stop at nothing,' director says

A precertification program at University of California at San Francisco (UCSF) Stanford Healthcare is turning around — in advance of service — 60% of all denials of coverage that come through the department, says **Sherry Kraft**, assistant director of admitting/precertification.

In a 16-month period, the program's six staff members, including two registered nurses, brought in \$1.25 million in revenue that otherwise would have been lost, while guaranteeing that patients involved would receive the best possible care, adds **Dorothy Marian**, RN, one of the two precertification nurses.

"We stop at nothing," Kraft says. That can mean, she adds, getting physicians on the phone to explain a procedure, faxing the review organization clinical articles on the latest treatments, or, in one recent case, tracking down an insurance salesman to get information backing up a patient's claim.

The critical success factor, she says, is the trust established between the precertification staff and the offices of the 100 physicians who are part of the UCSF Stanford Healthcare system. The key to that trust is timely and consistent communication, Kraft adds. "We send the physician's office a letter about what has happened, and we also communicate verbally. We keep them in the loop."

Clinical expertise a must

The clinical expertise of the precertification staff is crucial to the program's success, she says. Of the four non-nurses, Marian points out, two have graduated from nursing school but have not yet taken state licensing exams.

"We're very proud of the fact that we've been able to appeal denials prospectively," Kraft says. "If the review organization has denied access, but we know because of the complexity of the case it should be handled here, we will work with the physician's office and do what it takes to get the [denial of the] case overturned. [At other facilities], they might just accept the denial, and the patient would not get the care."

The typical precertification process, Marian explains, goes as follows:

1. "The physician clinics will fax us the demographics and any clinical information on a case. I call the insurance company and make sure the benefits are in place, and then I call the review company and present the clinical information. Sometimes I reverse the calls, depending on how complex the problem will be. Then I create the account in the computer and talk to the patient to make sure he or she doesn't have information we don't have, like the fact that the insurance company has changed. Then I clear it in the system, and the patient is ready to come in."

2. The precertification employees have a clinical database available to them, and the non-nurses use the RNs as resources on more complex cases, Marian notes. Knowing the kind of information review organizations typically ask for is much of the battle, she adds. "If it's cancer, they want to know how it was diagnosed. If it's heart surgery, they want to know what the cath [cardiac catheterization] report showed. You don't need a whole lot of clinical information once you realize what they want."

Getting the go-ahead

At UCSF Stanford, all elective inpatient and outpatient procedures must be financially cleared, Marian says. "If not, [the case] is delayed or postponed or referred to a financial counselor. We keep the physicians' offices informed that there are problems."

The system works best if the precertification staff are aware of cases two to four weeks in advance of service, she says. "We are working two to three weeks out most of the time, but sometimes it's five days, or the next day." In a recent case of an abdominal aneurism repair, Marian notes, the final OK was obtained the night before surgery.

In that case, the vascular surgeon, who was with a health plan outside the UCSF Stanford system, believed a stent repair was the appropriate treatment, she says. Request for treatment at UCSF Stanford was denied by the patient's HMO, which maintained the treatment should be done in-plan, Marian adds. "No one in that plan could do it, but they still denied service at Stanford. We worked with the outside vascular surgeon and a physician from the review organization to turn that [denial] around."

When a gastric bypass for obesity was initially

denied as noncovered, "we indicated clinical comorbidities, went to the medical director of the insurance company, and he turned it around," she says.

In another case, the staff turned around a denial involving a so-called pre-existing condition, Marian explains. "The patient stated he had been diagnosed on a particular date, after the policy was bought, but the insurance company wouldn't authorize the treatment. Supposedly the information had been faxed to them, but it never got through."

Accountable for complete episode

Until it's proven otherwise, the insurance company assumes a condition is pre-existing, adds Marian. "Because the patient had not had insurance prior to this, there was no 'rollover' or state law that would protect him. He was a young man with metastatic cancer and really needed the treatment, which would have cost him about \$30,000.

"We called the person who sold the insurance policy," Marian says. "He went to the physician's office, got the records, and faxed them to the insurance company to prove that the condition came up after the patient was enrolled."

Formerly a part of the social work and case management department, the nine-year-old precertification program merged into the admitting department a little more than a year ago, Kraft notes, soon after Stanford merged with UCSF Medical Center in November 1997. Stanford had the original program, which is now being piloted with one nurse at the UCSF Stanford north campus facility, she adds.

Recently, the registration workflow was changed, Kraft points out. "It used to be that the precertification staff just dealt with clinical justification. Now they're doing all the preregistration, verification of insurance eligibility, plus the precertification. Because they don't hand off the case, they are accountable for the complete episode." ■

Need More Information?



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Staff are in sweats, jeans, but the work gets done

Saturday sessions foster teamwork

Saturday staff retreats, held every six weeks at her home, are helping one regional admitting director keep managers at the 10 hospitals she oversees "on the same page."

Learning the different cultures at the hospitals that now make up the Clearwater, FL-based Baycare Health System is the biggest challenge of her job, says **Martine Saber**, CHAM, director of admitting. "We're spread out all over the place," she adds. "One hospital is 60 miles away, and others are 20 to 30 miles from each other." There are 12 managers and a total of 219 full-time equivalents (FTEs) at the 10 hospitals.

Standardization of policies and procedures is the ultimate goal, Saber says, but getting there is a complicated process of determining best practices and gaining buy-in from managers accustomed to doing things their own way. The staff retreats are a forum for brainstorming and for assessing "where we are with our goals," she notes.

Casual environment makes it fun

Originally, the plan was to meet quarterly, but Saber says she quickly realized there was too much to cover to wait that long between sessions. The managers come in shorts, jeans, or sweats, she notes, and "we try to make it fun. I feed them and have little gifts for them, and we talk about what we've done."

For example, Baycare is gradually implementing bedside registration in the emergency department (ED), and three of the hospitals have achieved that goal. The retreats give managers, who consider the retreats a part of their job responsibilities, an opportunity to update each other on what has been accomplished, Saber says.

"We start our meeting with quality," she adds. "We talk a lot about the good things first."

Saber occasionally schedules guest speakers. They have included a motivational speaker well-versed in quality management; Saber's boss, Baycare's regional vice president of finance, who talked about the coming year's budget and goals; and the health system's director of corporate

(Continued on page 31)

Registration Cost Worksheet

1998 Budget		OP	IP	OP/CS	IP	IP/OP	ER/DSC/HV	IP/OP					
		\$ 126,639	\$ 295,524	\$ 418,802	\$ 312,477	\$ 356,875	\$ 415,228	\$ 294,355	\$ 331,080	\$ 873,003	\$ 256,586	\$ 380,336	
		5.8	11.5	16	11.7	15	17.2	12.5	13.7	32.3	12.9	12.2	
Emergency Dept		SAH	SAH	BMC	BMC	MPH	MPH	MD	MC	SJH	SFBH	SJOW	TOTAL E.R.
Expenses		\$193,707			\$409,956		\$241,412	\$158,952	\$198,165	\$802,595	\$167,079		\$1,971,865
ED Visits		37,282			56,909		43,000	21,939	32,485	89,000	18,400		\$299,015
Cost per visit	99	\$5.20			\$7.20		\$5.61	\$8.59	\$6.10	\$6.77	\$9.08		\$6.69
1998		\$5.85			\$7.40		\$6.38	\$9.02	\$6.91	\$7.17	\$7.95		\$7.12
FTE's	99	7.3			14.7		10	6.75	8.2	22.5	8.4		77.85
1998		8.09			14.65		11.1	8.2	9.56	22.85	8.37		82.82
Reg per FTE/yr	99	5,107			3,871		4,300	3,250	3,962	3,966	2,190		3,841
1998		4,219			3,641		3,770	2,609	3,382	3,789	2,832		3,542
Best Practice	0	\$0			\$0		\$0	\$0	\$0	\$0	\$0		\$0
Savings		\$193,707			\$409,956		\$241,412	\$158,952	\$198,165	\$802,595	\$167,079		\$1,971,865
Admitting		SAH		BMC	MP	MP	MD	MC	SJH (IP/OP)	SFBH	SJOW	TOTAL I.P.	
Expenses		\$64,244		\$178,940	\$171,300		\$47,097	\$38,666	\$337,849			\$214,365	\$1,052,462
IP Admission		17,427		19,087	27,627		9,050	11,519	65,579			32,342	\$ 182,631.0
Cost per visit		\$3.69		\$9.37	\$8.20		\$5.20	\$3.36	\$5.15			\$6.63	\$5.76
FTE's		2.5		6.7	7.2		2	1.8	12.5			6.7	39.20
Reg/FTE/year		6,971		2,849	3,837		4,525	7,199	5,246			4,827	4,659
Best Practice	0	\$0		\$0	\$0		\$0	\$0	\$0			\$0	\$0
Savings		\$64,244		\$178,940	\$171,300		\$47,097	\$38,666	\$337,849			\$214,365	\$1,052,462
Financial Counselor		SAH		BMC	MP	MP	MD	MC	SJH (IP/OP)	SFBH	SJOW	TOTAL O.P.	
Expenses		\$128,489		\$80,122						\$297,308		\$143,976	\$649,895
IP Admission		17,427		19,087						40,643		19,532	\$ 96,689.0
Cost per visit		\$7.37		\$4.20						\$7.32		\$7.37	\$6.72
FTE		5		3						11		4.5	23.50
Case/FTE/ year		3,485		6,362						3,695		4,340	4,114
Best Practice	0	\$0		\$0						\$0		\$0	\$0
Savings		\$128,489		\$80,122						\$0		\$0	\$0
Bed Control		SAH		BMC	MP	MP	MD	MC	SJH	SFBH	SJOW	TOTAL O.P.	
Expenses		\$51,395		\$66,617						\$156,762			\$274,774
IP Admission		17,427		27,627						34,319			182,631
Cost per visit		\$2.95		\$2.41						\$4.57			\$1.50
FTE		2		2.8						6.8			10.60
Case/FTE/ year		8,714		9,887						5,917			17,229
Best Practice	0	\$0		\$0						\$0			\$0
Savings		\$51,395		\$0						\$0			\$0
Total Admission Cost		SAH	SAH	BMC	BMC	MP	MP	MD	MC	SJH	SFBH	SJOW	TOTAL O.P.
Expenses		\$244,129		\$259,062	\$237,917		\$47,097	\$38,666	\$791,919			\$368,341	\$1,977,131
IP Admission		17,427		19,087	27,627		9,050	11,519	65,579			32,342	\$ 182,631.0
Cost per visit	99	\$14.01		\$13.57	\$8.61		\$5.20	\$3.36	\$12.08			\$11.08	\$10.83
1998		\$15.31		\$10.13	\$0.00		\$4.56	\$3.76	\$0.00			\$0.00	\$216.49
FTE's	99	9.5		9.7	10		2.0	1.6	20.3			11.2	64.30
1998		10.87		11.71	0		2.1	1.8	0			0	0
Reg per FTE/yr	99	1,834		1,968	2,763		4,525	7,199	3,230			2,888	2,840
1998		1,592		2,988	-		5,163	6,215	1,504			3,966	0
Best Practice	1/20/99	0	\$0	\$0	\$0		\$0	\$0	\$0			\$0	\$0
Savings		\$244,129		\$259,062	\$237,917		\$47,097	\$38,666	\$791,919			\$368,341	\$1,977,131

Source:
Charts here
and on p. 31
are courtesy of
Baycare Health
System,
Clearwater, FL.

Registration Cost Worksheet

(Continued)

		OP/DSC	SAH	BMC	MP-OP	MP-DSC	MD	MC	SJH	SFBH	SJOW	TOTAL O.P.
Expenses		\$82,970	\$215,945	\$95,167	\$101,393	\$45,919	\$70,083		\$49,726			\$661,203
OP Visits		27,565	55,457	26,929	22,144	25,330	31,419	\$12.23	10,846	\$4,68		199,860
Cost per visit		\$3.01	\$3.89	\$3.63	\$1.81	\$4.68	\$1.81	\$3.85	\$9.71	\$4.68		\$3.31
FTE's		99	3.8	\$2.46	4	4.2	1.96	2.9		2.6		\$5.30
Reg per FTE/yr		99	4.81	8.26	7.36	3.96	5	3		4.5		27.60
Reg per FTE/yr		99	7.264	6,722	6,732	5,272	12,990	10,834		4,338		53.65
Best Practice		1998	7.863	10,557	6,059	3,936	7,780	6,064		2,317		7.236
Savings		0	\$0	\$0	\$0	\$0	\$0	\$0		\$0		\$0
Total Expenses		\$82,970	\$215,945	\$95,167	\$101,393	\$45,919	\$70,083		\$49,726			\$661,203
Total Volume		\$20,806	\$84,963	\$675,888	\$251,968	\$306,914	\$1,394,514	\$1,216,805	\$398,341	\$4,610,199		
99 Total CPR		\$6.33	\$6.73	\$131,453	119,700	56,319	75,423	154,579	\$29,246	\$4,342		681,336
1998 Cost/Registration		\$6.33	\$6.66	\$5.66	\$5.66	\$4.47	\$4.47	\$9.02	\$7,41	\$11.08		\$6.77
99 Total FTE		20.8	32.7	\$6.33	\$6.32	\$5.63	\$5.34	\$10.41	\$8.49	\$13.38		\$7.29
1998 Total FTE		23.77	33.75	32.05	28.2	10.7	12.7	61.8	10.9	11.2		179
Total Reg/FTE/Yr		5,324	6,367	6,668	7,016	7,916	3,978	3,978	12.87	14.13		200.56
Exp. not included in Cat.		\$43,669	\$51,395	\$202,857	\$61,303	\$23,792	\$72,423	\$42,387	\$106,112	\$39,781	\$31,995	\$721,880
Scheduler		2	6.75									8.75
Birth Certificate												0.80
Data Clerk			1		1							4.00
H & V Reps.												2.00
Cashier												2.00
Manager			1	1	1	1	1	1	1	1		1
Total Hspcl Expenses		\$615,670	\$1,169,123	\$772,103	\$294,365	\$331,080	\$1,502,626	\$256,596	\$360,396	\$5,332,079		207.30
TOTAL FTE												

compliance. "At our next meeting, we may have someone from human resources," she says. "All the managers seem to have problems handling family medical leave and want to know what their rights are. When I see there's a pattern like that, I invite someone who can help."

Although tiring, the daylong retreats are popular with managers, she says. "They see, from beginning to end, how much better we know each other. We laugh and have a good time, but we really work. By the time we go home, everyone has assignments for next time."

One of the goals for the coming year, she notes, is to form teams, of perhaps four managers each, to look at the system's policies and procedures. "We'll have one team look at the ED, for example, and another at financial counseling. "They'll rewrite [policies and procedures] and give them to the entire group to review."

Cost per registration examined

As part of the drive toward standardization, Saber and her managers are monitoring the cost per registration at the Baycare hospitals, she says, with a goal of reducing those costs by 5% by the end of 1999. As a baseline, she is using the budgeted figures for 1999, dividing the department's monthly expenses by the number of projected registrations that month.

Using a grid designed with help from her boss, she determined that overall registration costs range from \$4.07 to \$11.36, with an average cost throughout the Baycare system of \$7.29. (See registration cost worksheets, pp. 30-31.)

Because the hospitals vary in staff makeup and services provided, Saber is breaking out costs for specific functions. For example, some hospitals have cashiers and others don't, and some have bed

control and others don't. Emergency department costs were the simplest to compare, with a range of \$5.85 to \$9.02 among the facilities. "It's OK to be a little different [in costs], but we're trying to break down the variables. I want to look at where we're spending more and why." For example, she asked, "Am I top-heavy [in staffing]?"

Other factors also figure into the equation, Saber points out. One of the facilities that is highest in cost per registration, for example, takes in some \$500,000 per year in upfront cash collections.

Getting a handle on the cost per registration, she notes, will help her meet the 5% cost reduction goal. "We'll reduce waste and streamline our processes by benchmarking with each other and with other hospitals across the country," Saber says. The plan is that the increased efficiency will allow staff levels to remain the same as patient volume increases, she adds.

As part of the ongoing examination and comparison of procedures at the various Baycare hospitals, Saber and her managers already have made some improvements, she points out.

"One change is in our outpatient area, where we've really been stumbling a lot in getting authorizations," she says. "We don't have an automated way to let registrars know that authorization is needed for a certain procedure. They use 'cheat sheets' [to check the rules for different insurers] and each registrar was calling for authorization after finishing the registration."

At one Baycare hospital, the procedure was changed so that one registrar became "the insurance person," she says. "That registrar spends the whole day calling for authorizations."

After one quarter, the number of cases in which an authorization was not obtained before service dropped from 633 to 74, she notes. The next three-month period saw a drop to 27 cases, and the next, the figure was 47, she adds.

Still, there is resistance from managers who say if their way of doing things is working, why change it, she says. "I haven't been pushing them because I want them to come up with [the changes] themselves." For those who think their way is best, "I say, 'Start measuring.'" ■

Need More Information?

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GUEST COLUMN



Will 'wireless' work in a real-life setting?

Examples show technology's pros, cons

By Matt Hisle, PE

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

Speaking in the fourth century BC, Chinese general Sun Tzu said, "No battle plan ever survives contact with the enemy." The same can be said for technology. What looks wonderful on paper may not always work in a real-life hospital environment. The health care institutions that are the subject of this article have actually implemented wireless solutions. These case studies provide important lessons regarding what works, as well as what doesn't work.

Emergency transport: Beginning the cycle

Delivering care to the patient's location, regardless of where that might be, has long been the domain of emergency response teams, paramedics, and emergency medical transport services. With recent advances in handheld computing and wireless data communications, we are able to put a powerful new tool in the hands of these teams and improve the financial picture for service providers at the same time.

At a regional emergency medical service (EMS) in the South, three companies — Zoll Medical in Burlington, MA, Westech Mobile Solutions in Vancouver, BC, and AccuMed Billing in Riverview, MI — teamed up to provide a system of applications and services targeted directly to the emergency medical patient served in the field. Each emergency medical technician (EMT) and paramedic is provided with a customized handheld pen computer that provides a variety of information.

Specifically, this device guides the EMT/paramedic in diagnosis and treatment, provides information on potential complications, and

speeds record-keeping and billing. By virtue of its ability to guide the user through a series of input menus, the system creates an electronic record of the emergency call that is uploaded to the appropriate information system. This electronic record replaces the messy and sometimes unreadable paper record (run report) commonly developed.

Not only does this system improve the speed and quality of care delivered to the patient before arriving at the hospital, it vastly improves the information flow. The patient record is available quickly and accurately in a paperless format. This process avoids courier costs for paper records and reduces data entry and error correction time, thereby significantly reducing processing costs.

At the EMS claim billing end, the real value is in the improved accuracy of the initial run report. Because you cannot go back and change a run report, and because many run reports do not use accurate terminology to describe symptoms, errors abound, which can increase rejected claims.

As a result of improved accuracy (such as correctly identifying an advanced life support vs. a basic life support run, the correct ICD-9-CM codes can be submitted and compliance maintained. Preliminary estimates indicate that increased reimbursement revenue from improved accuracy can result in a 10% to 15% improvement in revenue associated with emergency transport.

These improvements do not come without problems, however. High-rise buildings and tunnels make real-time data communications less reliable than desired, so backup data download systems are necessary. Additionally, extensive training is required for emergency medical staff. Applications that require perfect entry all the time may result in frustrated end-users. The costs for hardware, software, and communications may be prohibitive. However, as companies such as AccuMed begin to share both the costs and the benefits with the systems users, total cost of ownership for the emergency system could become reasonable.

Once a patient arrives at the hospital, registration and paperwork can be a daunting process. In 1997, two hospitals in the Midwest began a pilot test to implement the use of portable laptops to speed the registration process for emergency department patients. The hospitals allowed roving medical staff to access and input information into the patient management database in real time, using a Proxim Wireless LAN and a TCP/IP network doing terminal emulation.

The staff collected such primary information as the reason for the visit, type of insurance coverage, and basic personal health history. Patients were interviewed in private treatment rooms, sometimes as treatment was being provided.

From a patient service perspective, the results were very positive. Patients perceived that care was provided faster, information was obtained in a more private environment, and most importantly, patients no longer sat in a waiting room engrossed in paperwork. The hospitals eliminated all but two registration tables, and staff spent more time attending patients than ever before.

On the downside, battery life was a significant problem. The staff had to continually re-charge the system. Other concerns included:

- effectiveness of integration with clinical and financial systems;
- care and handling of antennas;
- speed of the laptop;
- dependence on single point of failure access points.

Wireless phones enhance neonatal care

At a Midwest regional hospital, wireless phones were instrumental in implementing a "quiet hospital" program targeted in the neonatal ward. The health care professionals were sensitive to the negative impact of excess noise on newborns, and ringing phones and beeping pagers were major culprits. Each nurse was equipped with a portable phone that would vibrate or chirp softly when ringing, and all other phones and beepers in the area were banned.

In conjunction with other noise reduction efforts, average sound levels dropped significantly. According to the nursing director of the neonatal intensive care unit, while this program reached its primary goal, other more subtle benefits were observed:

- Because they were freed from a traditional desk, nurses tended to spend much more hands-on time with each infant, and they reacted more quickly to problems.
- Nurses were able to increase their communications with each other and with other health care professionals.
- Communications with parents increased dramatically, and satisfaction with hospital services went up accordingly.

Saying to a new father, "I am here with little Susan now, and all is well. Do you want to hear

her?" turned out to be a quite powerful experience for hospital staff.

Nonetheless, there were problems with the technology:

- The phones were one more thing to carry around, and several experiments were necessary before a comfortable method of wearing the phones evolved. As it turned out, one common method was not enough. Different individuals developed different approaches, some even using headphones for better hands-free access.
- New protocols had to be developed to ensure maintenance of appropriate sterility levels.

In the hospital: Patient charting

In many hospitals, clinical care nurses are experimenting with better ways to interact with their patients and their computers. One of the most common applications has been patient charting. A large Southern health care system is now working on its third generation of systems to improve nurse bedside time with patients, accuracy of information, and information availability.

The hospital implemented an Eclipsys package of hardware, software, and Proxim communications systems designed to provide portable links into the hospital clinical information system.

As currently implemented, a custom-built wireless appliance is created by installing a flat panel display, a computer/X Terminal emulator, a transceiver, a keyboard, and a large battery on a device that looks like an IV pole. These are stored in convenient locations on the floor, in the hallways, or in patient rooms, and, when needed, they are "grab and go." These systems are primarily used for patient charting, directly entering patient vital sign information.

On the plus side, the system has learned from these pilots that:

- Where other computer terminals are scarce, these systems are used constantly, and user satisfaction is high.
- These systems allowed the hospital to avoid constructing and wiring a large number of dedicated workstation locations.
- Some doctors (particularly in urology) have begun using the systems to obtain clinical information access at the patient's bedside.
- Use of these systems has increased the time spent bedside and on direct patient care, eliminating trips to the central nurses' station and

eliminating paperwork associated with writing information, then re-keying it into the computer.

- Information quality and speed of availability has increased.

On the downside, the system found that:

- These systems demand end-user education or they will end up cluttering the halls.
- Proximity of fixed computer workstations dramatically decreases utility of the systems.
- Reliability is a key to continuous use. Poor reliability from telecommunications problems and software or hardware problems rapidly leads to rejection of the system.
- The wireless communications system does not interact well with a fixed IP address scheme. Installers must be careful of overlapping zones and dual hosting, particularly with multiple segment addressing schemes.
- The IV pole has proven to be bulky and hard to handle. It is one more thing for the nurse to carry into the room. Experiments to mount similar systems on med carts appear to offer better ergonomics.
- Physicians and nurses are much more interested in handheld units, even if less information can be effectively entered and displayed.
- Costs of the current system do not allow for rapid payback of investment. The best uses are in areas where patient charting must be done often and on a regular basis.
- The restrictions and capabilities of the computer information systems department will determine much of the system architecture and usability for the nurses.
- Physicians don't want to type, so usage has been low.

The health system has two new wireless pilots under development addressing this application. Right now, the downsides have not been worth the time and investment in these systems, but the long-term benefits are so compelling that the hospital is willing to invest time, energy, and money in continuous improvement.

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If you have a successful or unsuccessful program, pilot, or installation story on wireless technology, please e-mail Hisle at Matt_Hisle@enterprise.supc.com.] ■



Enhance success with five steps to better training

Check work environment first, expert says

By Louis Phillips, EdD
Greenville, SC

Training does not always produce the results you desire. This is question to ask yourself: Is training the culprit, or is something else mitigating the training? Actually, both can be at fault. By following the suggestions discussed below, you can greatly enhance your chances of success.

- **Analyze problems and issues that exist in the trainees' work environment.**

Having interviewed thousands of employees in preparation for developing training programs, I am always struck by two major points they make. First, they desire to do a good job — to perform well. Second, they are often unable to perform well because of problems in their work environment, such as lack of good and timely information, outmoded equipment, lack of clear procedures, lack of appreciation and recognition, or a lack of feedback.

These environmental conditions over which the trainees have no control are not training problems. They create frustration and motivational problems because they interfere with the individual's desire to do a good job. Remember Abraham Maslow's hierarchy of needs?

The top motivators in the workplace, according to psychologist and author Frederick Herzberg, are a sense of achievement, recognition, and the enjoyment of work. Employees often do not experience these motivators because of environmental problems. When asked to attend training, their willingness to learn is blocked by frustration about things over which they have no control.

They know if factors or conditions blocking their performance were removed, they could perform at a higher level. They feel frustrated because training often is substituted for the more realistic need of cleaning up their work environment. Trainers often hear participants say, "I wish my boss was here to hear this." It's because their

bosses are generally responsible for the environmental conditions that create those frustrations.

The critical first step in any planned training initiative is to identify problems and issues in the work environment that prevent staff from performing their best. If staff are going to be trained on a new system, they should be asked to identify potential problems and issues that might prevent the new system from working effectively. This is usually achieved through a series of focus groups.

Problems should be resolved before or during the training. Corrections not only allow staff to work more effectively; but they also reduce the employee's resistance to the anticipated training.

Since most problems are under the control of management, removing them is a visible sign to employees that management cares about the outcomes of the training. In fact, resolving these problems and issues can sometimes eliminate the need for training. On the other hand, failure to resolve them can limit or doom the training.

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Editorial Questions

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- **Spread training out over a period of time.**

Hospital administrators often determine when training will begin and how long it will last with little or no input from those responsible for the training or for supervising its results. Consequently, a lot of training is done in a rush so the administration can say, "We've got everybody trained." Often, this results in staff being exposed to lots of information but not sufficiently trained to change their behavior. Behavior change comes about slowly. People learn and remember best when they are trained in small chunks (for example, being given limited information at any one time). Staff need time to digest and use those small chunks back on the job before receiving more training. Research on this issue has proven conclusively the benefits of spreading training over time.

- **Develop job aids.**

Staff do not need to keep all information necessary to their jobs in their heads. Increasingly, we use manuals, disks, tapes, and computers to store information that can be retrieved when needed. Job aids can do the same thing for employees, especially for tasks that are complex or done infrequently. These include checklists, charts, reference materials, flowcharts, and algorithms.

Trainers can have staff develop these job aids as part of their training. Such an activity provides training practice and allows them to personalize job aids to their particular situations. Also, job aids are increasingly being developed on computers to provide performance support.

- **Make training relevant and personal.**

Every trainee comes with one basic question: "What's in this for me?" (WITFM). They pay attention, listen, and process only information to which they personally can relate. Training is so often focused on the hospital or patients that it fails to consider the WITFM question of each trainee. A more effective approach is to examine the trainees' status, including knowledge of their work environments, knowledge and skill levels, attitudes, and desired changes in performance. After all, it's the trainees' behavior you are trying to change. Or put another way: "When the boat misses the harbor, it is rarely the fault of the harbor!"

- **Practice, practice, practice!**

A major reason trainees do not implement in the workplace what they learned in training is a lack of confidence. They simply do not feel they understand their new tasks well enough. When there is doubt, they tend to revert to their old ways of performing. Practice builds confidence. Practice allows trainees to make mistakes, to

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receive feedback, to be coached and to make corrections until their performance is acceptable. It allows trainees the opportunity to "personalize" their learning — to do what each finds necessary to perform correctly back on the job.

Generally, trainers present too much information to trainees with little or no time for processing or practice. The idea that all possible content must be delivered in hopes the trainees will use it is an outdated notion. The focus instead should be on the "essential" pieces of content and using practice to reinforce that content.

The preceding ways for achieving better training results are based on how employees perceive and process training. Too often, one or all of these suggestions are overlooked, thus creating barriers to learning and performance change. Every training program should begin with an understanding of whose performance the training is designed to change and what is required to change that performance. When training fails to bring about those changes, don't blame the trainees. Instead, determine why the boat missed the harbor!

[Editor's note: Phillips has been an adult educator for 32 years. He writes, trains, and demonstrates effective educational practices designed to change performance. He can be reached by calling (864) 268-8822 or e-mail at louphil@home.com.] ■