AMERICAN HEALTH CONSULTANTS®

FOR 19 YEARS

Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

February 2000 • Vol. 19, No. 2 • Pages 13-24

IN THIS ISSUE

In This Issue **continued on next page**

NOW AVAILABLE ON-LINE! www.ahcpub.com/online.html

American Health Consultants® is A Medical Economics Company

Don't fear consultants — just educate them first

Make sure outside firm grasps your staff's abilities

The idea of working with an outside consultant can strike fear into the hearts of access managers, but it doesn't have to be that way. Several access professionals who have had productive encounters with consultants share with *Hospital Access Management* the ways they've found to maximize the experience — and come away with information they can really use.

Before consultants can give you effective advice, you must give them the necessary education, says **Anthony M. Bruno,** MPA, director of corporate admissions and registration at Crozer-Keystone Health System in Chester, PA.

"Consultants quite often, not consciously, have certain ideas based on their experiences that they think will be helpful," adds Bruno, "but they just don't fit into the culture of the organization. Try to give them a sense of perspective for the history of the department — where you've been, where you are, where you think you're heading — so they can fit their ideas into the situation."

Make sure consultants have, for example, a realistic picture of the skills and ability of your staff, he says. If 10% or 15% of the staff are the "worker bees," another 10% or 15% don't contribute a lot, and the remainder are followers who are somewhere in the middle, the consultant needs to know, Bruno points out.

"If you have a larger group on top [the worker bees], then you can do more with less, but typically you don't have that," he says, "which makes it more difficult to pull off goals and objectives. You can't cut [staff] across the board." Consultants should be aware that cutting a staff of 25 down to

In This Issue **continued from page 13**

COMING IN FUTURE ISSUES

- When physicians don't get preauthorizations
- How the Internet figures in access strategies
- One health system's ambitious collections goal
- Expanding access horizons
- Whatever happened to 'patient-focused care'?

20 may seriously hamper operations because the most productive people may not be those with the most seniority, Bruno adds.

Point out that [the solution] may not be about cutting staff but about increasing revenue, he suggests. "If you have more staff, you can do a better job of collecting deductibles, providing financial counseling. It's about thinking out of the box."

Don't feel threatened by consultants. Just think of them as another resource, Bruno adds. "Don't be scared to give them information. If you work with them and show you want to be part of the solution, you get better results."

A good consultant will hear about disparate issues and comprehend not only what the issues are, but how they affect the institution, says **David Morgan,** managing partner of Health Care Systems Management, a consulting firm in Framingham, MA. **(See related story, p. 15.)** "People will tell you what they think is the answer, but if you talk to four people, you get four different answers," he says. "The consultant must be able to sit back and say, 'This issue in preregistration is related to that issue in pharmacy.'"

Do your comments resurface?

A common complaint among access managers is that they see their own comments parroted back to them in a consultant's report. However, that's not always a bad thing or even a cop-out on the part of the consultant, Morgan suggests. Staff many times are too busy to "sit back and take a global view," he says. "They knew [what was wrong] but didn't have time."

Because many hospitals have eliminated their management engineering departments, there are often no internal resources to do the work, Morgan notes.

"Line employees tell me things I never heard, and I'm going to use [that information]," he adds. "[Clients] will see a lot of those suggestions in my work product. There's someone listening to take this stuff and give it a form."

On the other hand, many institutions fall into the trap of "throwing a lot of money, getting a report, and considering they've looked into it," Morgan points out, which is also a mistake. He cites one meeting in which three people were talking about what should be done at a particular hospital and not one of them was a member of the staff. "They were busy doing other things."

Martine Saber, CHAM, director of patient

access services for Baycare Health System in Clearwater, FL, says she experienced the counterpoint to that situation in her dealings with a consultant brought in to address her organization's accounts receivable (AR) days.

The consultants, part of a small firm, worked closely with Saber's staff, she says, giving them their first true understanding of how admitting operations affect AR days. "Admitters hate collecting cash, but now they understand that cash collections bring AR days down. Now we all own the AR days and are finding new ways to collect cash."

The consultants paid her department a high compliment, Saber says, noting in their report that "our process was so tight and so good that they didn't find any of the lost error days coming out of admitting." They did point out, however, that the department's training process was lacking and went to work remedying the situation, she adds.

"They put a training program together and gave us a computer training manual explaining the different kinds of insurance, why it was important to call for authorization, and what happens if we don't get it."

Staff historically were trained on the computer and then "thrown to the wolves" because there was no time to help them understand why they did what they did, Saber notes.

"We had heard [consultants] would come in, change everything, and more or less tell us what's wrong, and then leave," she says. "[This firm] was very down to earth and asked, 'What do you need me to do? What can I do for you?'" ■

Avoid assumptions when consultant-hunting

Here's how to circumvent consulting nightmares

Health care institutions hire consultants for a variety of reasons. Employees may not have time to do the work themselves. An outside company can bring expertise the provider may not have. Someone may want to sell an idea to the board of directors and need a high-profile consulting company to back it up.

Whatever the reason, there is at least one disastrous consulting experience for every successful outcome. Sometimes, encounters with consultants simply leave access managers drained, frustrated, and feeling their institution threw a lot of money at a problem without getting tangible results.

There are several ways to help make the experience not only tolerable, but productive, suggests **David Morgan,** managing partner of Health Care Systems Management in Framingham, MA. Morgan, who has worked as a consultant on his own and with national firms, offers the following guidelines:

1. Avoid assumptions, on either side of the table.

When a hospital brings in a consultant to provide certain expertise, it's easy for that provider to assume the consultant knows what he or she is doing, Morgan says. At the same time, he adds, it's easy for consultants to assume the hospital is in agreement with what they're doing.

"When people bring in consultants and don't control them, the consultant may lose touch with the institution and where it wants to go," he says. "If you're not sitting down together on a regular basis, the scope of the project changes a bit. It may be a great job, but it's not the job the hospital wanted." The hospital staff's lack of time — one of the reasons it needed a consultant — can exacerbate the problem, he adds.

Morgan cites one situation in which consultants came in to do a job and approached it in the way they thought best. Meanwhile, the hospital liaison went on to something else as soon as he brought the consultants on board.

"In this case, the communication from the medical staff was not getting back to the consultant," he says. "By the time someone was brought in to rectify things, there was too much of a gap between the institution and the consultant — too much animosity."

2. Don't let a good rapport result in loss of perspective.

The flip side of the above problem can occur when hospital and consultant hit it off beautifully, Morgan points out. "If the consultant develops a really good rapport with an institution, [staff] are asking, 'Can you look at this and that?'

The next thing you know, the scope of the project is different, and the hospital has spent more money than planned or the original project is not fully done."

Schedule weekly, or at least biweekly, meetings with the liaison from the consulting firm to talk about where the project is going, he advises. "Lots of firms produce weekly reports, but those don't capture the flavor of personal meetings."

3. Don't end up with just a document for the bookshelf.

Consultants often are hired to identify problem areas, and there is some validity to that objective, Morgan says. The institution may use the findings in strategic planning and may implement changes as a result, he says. Too often, however, that approach means the hospital "ends up with a document for the bookshelf."

"I tend to like to do roll-up-your-sleeves consulting, in which I find and deal with with issues and become totally immersed in the institution," Morgan says. The most effective outcomes, he suggests, are when the approach is, "I have a problem — fix it."

The most expensive part of hiring a consultant is the time it takes to learn the issues, Morgan says. "Usually, the least expensive part of the project in terms of manpower and time studies is implementing the solution. But many times, people don't go there and don't resolve their problems.

"Come to some sort of conclusion as to what the work project will be, with a definite outline of what the product will be," he adds. "You don't want to end up with a document and a problem not fixed."

4. Benchmarks are just tools.

"One thing I see a lot is hospitals trying to take an idea from one place and implement it somewhere else," Morgan says.

It's not appropriate to compare registration times when one hospital uses a point-of-service device to swipe cards, another is on a computer network that automatically retrieves information, and another relies on verifying insurance over the telephone, he says.

One institution he worked with had the technology to do remote registrations but made the decision that good patient care requires personal contact with the patient, Morgan notes.

"There are horror stories," he adds, "of consultants coming in and saying, 'This is how we're going to do it.' They never worked with the staff, and the moment [the consultants] walked out the door, it falls apart."

5. Look at different types of companies before hiring a consultant.

Although there can be more prestige or credibility associated with a "Big Five" consulting firm, many times a smaller firm can stay more focused on a hospital's project, Morgan says. "People hire consultants for a lot of different reasons. Generally, when hospitals are looking to explain or sell something to the board, they tend to go with a high-profile company. I've actually done work and had the work repeated by larger companies because they carry more weight than I do."

But with smaller firms, he points out, it's even more important to "make sure they have the expertise they say they do. Interview people, look at their book of business, see where they've worked and how. Results are a great thing. Take a look at outcomes and call references." ■

New call center brings service up, errors down

Mistakes are gone before bill drop

A new call center — consolidating precertification, preregistration, and scheduling for four hospitals — is sparking dramatic changes for Cincinnati-based Mercy Health Partners, says **Jane Lach,** RRA, MBA, regional director of access.

Since December 1998, when preregistration and precertification staff moved into a new geographically central building near the health system's headquarters, the registration error rate has dropped from 15% to 5% for one facility, and to 7% or 8% for the remaining hospitals, Lach says. The goal is 5% or fewer errors, she adds.

The goals for the center — which Lach was hired to establish — included the following:

- provide better customer service;
- make scheduling more convenient for physicians and patients;
- increase and improve preregistration;
- improve the rate of precertification to decrease payment denials.

The most important result of the new center — which added scheduling staff to its mix in February 1999 — has been to centralize the management of its functions, Lach notes. Error reports, for example, which formerly went to four different registration managers, now go to the call center manager, she says, and a new database tracks performance by facility and employee.

Four employees make up a quality assurance (QA) team that is a subunit of the call center, Lach explains. Team members check for registration errors during the pre-bill stage and make corrections on the mainframe computer prior to bill drop.

"We keep track of those mistakes in our database, so feedback can be given to the registrar that made the error," she says. "It's very helpful, an educational process."

Monthly reports are provided to on-site registration managers, and the QA team prints and publishes a monthly newsletter that informs staff of common mistakes and changes in insurance requirements, she says.

The challenges involved in making the center a reality, Lach explains, can be broken down as follows:

1. People issues.

Employees had to be transferred out of the individual hospitals into the call center, Lach points out, and some did not want to make the change. "They were converting from an environment where they felt comfortable to a larger work environment where productivity is monitored."

To aid in the transition, Lach gave early notice of the upcoming move and offered staff the opportunity to transfer to other departments in the hospital before the call center implementation. In the end, very few chose not to make the move, she adds.

There are 35 employees in the call center at present, and capacity for 52, Lach says. "I believe we'll be at that next year."

2. Designing the telephone system.

"At first, we thought we would have one telephone number, but we ended up with two," Lach says. "One is given to the physicians internally, and the other, which is considered the patient number, is in the telephone directory and on television." The reason, she notes, is faster service for physicians, who make the majority of the calls. The call center handles as many as 700 calls per day, with 500 on a slow day, Lach says.

The beauty of the automatic call distribution system is that it monitors staff productivity and evens out the workload, she says. If one employee is busy, the call goes to the next person, Lach adds. "The system looks at how long [an employee] has been on the phone and assigns the next call to [that employee]. Not every physician's office calls and schedules one patient. Some call in 12 at once."

3. Communicating with physicians.

"We were on a fast track, and communicating [the call center operation] to physicians was a real challenge," Lach notes. Rather than advertise a new phone number right away, Mercy left the existing numbers for each facility in place for the first four months of operation, she says. Physicians continued to call the same numbers they had in the past and reach employees responsible for one particular facility.

"During that period, we cross-trained all of the schedulers to learn the other hospitals' scheduling [requirements]," Lach says. "When we felt they were ready, we did a new marketing campaign and, in June, implemented the same number for all the facilities." The timing also was geared to the date the *Yellow Pages* come out, so the new number could be listed there, she notes.

There was some initial resistance to the call center from physicians, Lach says, primarily because they were "clinging to old ways. The radiologist, for example, liked knowing the scheduler was down the hall and he could poke his head in the door and make changes or inquire about his schedule for the next day."

The feedback from physicians has been positive, however, mostly because of the expansion in service hours, she notes. Before, scheduling took place five days a week, between 7:30 a.m. and 5 p.m. or 5:30 p.m. The call center is open from 7 a.m. to 8 p.m. five days a week and from 8 a.m. to 4:30 p.m. Saturday.

4. Cross-training.

Different services are provided at the various Mercy hospitals, and some more complicated services are done only at the larger facilities, Lach says. Not all the hospitals own a magnetic resonance imaging (MRI) machine, for example, so some employees had to be taught what questions to ask when scheduling an MRI, she adds.

A three-inch manual was created to explain the different services, she says, and to facilitate the

training, she hired an experienced health care manager to serve as access educator.

The call center implementation became more complicated in April 1999, when Mercy Health Partners acquired two more hospitals, which are now in the middle of reorganizing the admitting department, she notes. "We will be training [employees at those facilities] and bringing them into the call center in mid-2000."

So far, the call center has been improving service and accuracy, not reducing staff, she says. "In the future, we might be able to do that."

5. Reasons for denials complicated.

The consolidation is helping the health system get a handle on payment denials, but that takes time, she explains. "There are a lot of reasons for denials, but we're starting to identify patterns so we can change processes as needed."

Although the jury is still out, Lach says she suspects there is a high denial rate on "special" procedures that are not scheduled at the call center but still handled at the individual hospitals. One such procedure, for example, is a needle biopsy that must be done in the radiology department under computerized axial tomography scan guidance, she adds. "Radiology wanted to maintain control of certain procedures that require more resources, such as a physician in attendance."

With such cases, Lach says, there is no coordination of preregistration and precertification, which she thinks is causing a high denial rate. "If I can identify that, I can make a business case for our CEO and CIO saying the call center needs to schedule those patients."

Although no concrete data are available — primarily because no figures were kept in the past — the percentage of preregistered patients clearly has increased, she notes. That is particularly true for one facility, which was so short-staffed there was never time to preregister. "There were also long patient wait times in the admitting department."

Despite the progress made so far, there is much more to come for the call center, she points out. Key elements in the works include:

• **A Windows-based scheduling system, Pathways Healthcare Scheduling by Atlanta-based HBOC.** All schedulers will be trained on the new system, which can load preparatory information for outpatient testing, generate appointment reminders if needed, and perform appointment conflict resolution. The system also allows "scheduling sets," such as coordinating a test that requires a specific injection followed by a scan two or three hours later.

• **A predictive dialer, which will add efficiency to outgoing calls.** This will be used by the call center staff to make preregistration calls to patients and precertification calls to insurance companies.

Future plans include an on-line eligibility system to allow real-time insurance verification, and new technology for precertification, Lach says. The "voice mail" precert system would require the cooperation of third-party payers and physicians' offices, she notes. That technology allows an employee in the physician's office to dial in to a voice mail system and give all the information required for a precertification, just as if the caller were talking to an insurance company representative, Lach explains.

"It's a real timesaver," she adds, because instead of waiting on the phone, the access employee can move on to the next account.

(Editor's note: Look in future issues of Hospital Access Management *for more information on implementing the scheduling system and transitioning employees from the two new hospitals into the call center staff.)* ■

Bulky, costly forms get the boot at Asante

Face sheet savings are $50,000 annually

The traditional preprinted hospital registration form is on its way out at Medford, OR-based Asante Health System, thanks to a new forms management program that had its first tryout in the patient registration department. The program will save $50,000 a year in face sheet costs alone, says **Dianne Beebe,** regional manager for patient registration.

Documents previously were printed onto expensive, multicopy forms that had to be fed through a printer, then "torn down," stamped with an embosser card for identification, and distributed to various locations within the hospital, explains Beebe, who oversees patient registration at Rogue Valley Medical Center and Three Rivers Community Hospital, part of the Asante system.

Changing a patient's address or adding an emergency contact could result in reprints, she notes. Similarly, the department might print 1,000 or more "Important Message From Medicare" letters, for example, and then find that the Health Care Financing Administration had changed a requirement affecting the form, she says. At about $1 per face-sheet form, reprint costs could mount quickly.

With the forms management system from Atlanta-based Optio Software, an employee does the programming for the various forms on site, which means they can be edited as needed, Beebe says. "This is not only a cost saving, it allows us to always have the most up-to-date version of any form at our fingertips." The embosser mark is already on the sheets when they print out, she says, so registrars will not need to emboss the "Conditions of Admission," the patient's rights forms, or any of the documents associated with a registration.

"It allows us to have a form designed by us," adds **Sue-z Barnes,** project manager. "We can make changes as they come up. If we need to add a field or make a change on the face sheet, the next form we print will have that change."

In the past, Barnes notes, the request for a particular form would be sent to a printing company, which would send a proof back for approval. The hospital would order in quantities as high as 50,000 to get the lowest price, she adds.

The system also allows users to insert "logic" into the process, Barnes says. "We can tell [the program], 'If the patient is this type and has this insurance, we want these specific forms to print out.'" In the past, she adds, registrars would have to remember in some cases that a person is a Medicare patient and also an observation patient and pull the appropriate documents from other files.

Another plus is that the forms print in the correct order, so sorting time is eliminated, Barnes notes, and there are different tag lines at the bottom of the sheets, indicating they are to go to medical records or are physician copies. There are no barely legible copies because every form is an original, she adds, "and we don't have paper jams on the printer anymore. We can use a regular printer rather than one with a feeder on the side, which tends to jam."

The forms also can be directed to different printers, Barnes says. "If a patient comes in for physical therapy, the registrar can send the patient to that department, and the paperwork is there to let [the department] know the patient is coming."

In many cases, in conjunction with a telephone preregistration program, Optio will allow the patient to bypass the registration department completely, Beebe notes. "Also, the patient won't be involved in waiting while we're tearing down and assembling forms."

Part of the reason for implementing Optio, Barnes says, was the capacity for printing documents to remote locations. "Our goal is that all the patient's paperwork will print directly to the nursing station, instead of [registrars] having to deliver it. Everything [nurses] need from the admitting department will be at the printer, and they can set up the chart."

Card soon will be obsolete

Although the face sheets now have the embosser mark, registration still must send the embosser card up for nursing to use on other essential documents for the patient's chart, such as the nursing assessment form, Barnes says. Once Optio is implemented in the nursing department, the embosser card will not be needed for those forms. "We want to make sure the patient information packet is in one piece [for nursing]," she adds.

"Once nursing gets on-line with Optio," notes Beebe, "we will generate an account number [in patient registration], and the logic can be designed to identify what is needed for them."

Forms that are generated from outside the hospital, such as the physician's order, will either continue to be embossed or eventually may be identified with stick-on labels, she says.

The embosser card also is used to make labels for laboratory specimens, so Asante is looking to perform that function with another form of identification, such as a bar code system, Barnes says.

Next in line for conversion to Optio is the pharmacy form, a tracking document indicating which drugs are going to which patients, she says. "We're also looking at other high-usage, high-cost forms to see which ones we'll use Optio on."

The health system is developing a priority list to determine which department will be next, Beebe adds. She estimates it will take about a year to add all the appropriate hospital forms to the system.

Some forms pose more of a challenge than others, Barnes points out. "The emergency department charts are hard because of the way they're designed. They're two pages wide, on really big paper. We're looking at being able to do it on NCR paper, but it would be on two separate sheets." ■

Asante
HEALTH SYSTEM

2825 Barnett Road Medford, OR 97504
1505 NW Washington Boulevard Grants Pass, OR 97526
715 NW Dimmick Street Grants Pass, OR 97526

ADMISSION RECORD
THREE RIVERS WASHINGTON CAMPUS

ADMISSION DATE/TIME	DISCHARGE DATE/TIME	ROOM	M/S	PATIENT TYPE	SERVICE	MEDICAL RECORD #

SEX	BIRTHDATE	AGE	RELIGION	LAST ADMIT/DISCHARGE DATE	ACCIDENT TYPE	ACCIDENT DATE	ADMISSION BY	BILLING NUMBER

ATTENDING PHYSICIAN/ER PHYSICIAN	FAMILY PHYSICIAN	ADMITTING PHYSICIAN

ADMITTING DIAGNOSIS	ADMITTING PROCEDURE/DEPARTMENT	PATIENT BROUGHT BY	PREVIOUS NAME

DEMOGRAPHIC INFORMATION

PATIENT NAME/SOCIAL SECURITY#/ADDRESS/PHONE

GUARANTOR NAME/SOCIAL SECURITY#/ADDRESS/PHONE

SPOUSE-PARENT/ADDRESS/PHONE

RELATIVE/ADDRESS/PHONE

EMPLOYER INFORMATION

PATIENT EMPLOYER

GUARANTOR EMPLOYER

SPOUSE-PARENT EMPLOYER

EMERGENCY CONTACT

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

TERCIARY INSURANCE

FOURTH INSURANCE

OTHER INFORMATION:

UNIT REFERENCE #	MEDICAL RECORD #

ANESTHESIA ALERT

CANCER REGISTRY

VRE/MRSA

PHYSICIAN INFORMATION:

Final Diagnosis:

Operations:

Consultants:

Code Numbers:

PHYSICIAN'S SIGNATURE: **DATE:**

12/16/1999 13:53:26 **DOWNTIME COPY** PR3 9/99

Career Paths

Collaborative approach will boost access career

Effective communication a must

Collaboration is the key when it comes to using your access management skills and experience as a springboard for career advancement.

That's advice from **Anthony M. Bruno,** MPA, who recently assumed the position of director of corporate admissions and registration at Crozer-Keystone Health System in Chester, PA.

"Access skill sets have changed a lot over the past years, and the new one has to do with collaboration," says Bruno, whose last position was director of health care access management at Philadelphia's Albert Einstein Medical Center. "With risk contracts, you need to have supportive, collaborative arrangements between hospital and physician to be effective in dealing with patients and with insurance companies to make sure you're maximizing revenue potential and minimizing expenses."

Focused on the wrong customer

Many access directors concern themselves with one kind of customer, Bruno adds, when it's another kind that needs attention. "Link with the physician liaison services that come out of the marketing department," he suggests. "Help educate them about what you're doing, so they also can act as a resource for access services. They end up being advocates for us; we don't increase our staff or budget, *and* we're helping them do their job."

One of the ways to disseminate information on, for example, systems and processes in preadmission is to hold quarterly breakfasts or luncheons for physicians' staffs, Bruno says.

"Give concrete, specific information on how their staff can access services and how patients can access services. Provide them with telephone directories and improve their ability to get services more expeditiously through fax, Internet, or group e-mail."

There is often turnover at physicians' offices, so you can't just give the information once a year, he adds. "You should constantly think about marketing."

Another thing that prepared him for his move to the corporate access position, Bruno says, is his attention to enterprisewide solutions that affect other departments as much or more than his own. Bruno was the driving force, for example, behind the establishment of a laser jet print system for creating admission and registration forms. **(For information about another health system's implementation of that process, see story, p. 18.)**

Documents go to remote printer

The new system, which eliminates the need for an embosser, allows other departments in the hospital to receive documents directly through their own printers, Bruno says. When other departments complained about the plastic embosser plates and about receiving illegible copies of forms, he adds, "I thought about how I could come up with a solution to help them. We're doing it not as much for access management, but for our customers. [Access directors should ask], 'What do my end-use customers need?'"

In the end, Bruno points out, "It helped us, too."

Another enterprisewide solution he instigated at Einstein was a universal consent form that is now being used throughout the health system.

That kind of universal thinking, he adds, "says something about the leadership skill of not only the individual, but the department. You constantly have to think about how people feel about your department and raise the level of awareness of how important the access department is."

His approach to management, he says, can be summed up by a quote from Albert Einstein written on a poster he keeps above his computer terminal: "Imagination is more important than knowledge."

"I personally believe in that a great deal," he explains. "Do I have all the knowledge of patient registration, information systems, etc.? No, but I try to bring in people who have parts of that knowledge, and with imagination, create a more efficient and prosperous organization." ■

Take a look at a policy in black and white

'What we do on a daily basis'

At first glance, it might seem obvious, but then maybe not. What is the specific policy and procedure for how patients gain access to your facility? *Hospital Access Management* heard about the search for a hospital that had something down in black and white, and found an answer at Aurora HealthCare in Milwaukee.

Aurora's policy, which became effective in December 1994 and is updated each year, "was started simply to designate how patients will receive access," says **Rita Borowski**, CHAM, metro region director of patient access services. "We put in writing what we do on a daily basis."

The policy "pulls it together that a patient's ability to access service is everybody's accountability within the facility," she adds. "Admitting handles their stuff, nursing handles theirs. It stipulates exactly what anybody should do."

The following paragraph introduces the policy: "Any patient, regardless of race, color, religion, national origin, handicap, HIV or related conditions, financial status, sex, or age, who presents with a valid physician order for inpatient or outpatient services will be provided services as prescribed."

Under the heading of "patient admission/registration," the policy specifies that elective cases may be delayed if there is a need to consult with social services, financial counseling, or behavioral health services staff or to arrange for a translator or TDD services, Borowski says.

A patient assessment will occur to make sure delays are not medically detrimental, she adds, and the following four guidelines will be followed:

1. Code four will be called for any patient who collapses or is otherwise in a medical crisis.

2. If a patient is in stress, but not crisis, the patient will be taken to the emergency department (ED) triage desk.

3. If a patient is urgent or emergent but not in evident distress, the patient will be assessed as needed by the ED triage nurse.

4. An admitting physician will be contacted if any service is being delayed to make sure patient care is not compromised.

In the second section, the policy addresses the steps that will be taken if a patient is seeking medical services but does not have a valid physician order, Borowski says.

The first three guidelines mentioned above will be followed in such cases, she notes. The fourth step, however, will be to contact other service areas in case an order has come to those departments rather than to the registration area, Borowski adds. "We also check area hospitals to see if the patient is supposed to be there. Maybe a person shows up saying, 'I'm supposed to have a stress test,' but registration has no record of it, and the person has no paperwork. We make sure the patient is at the right location."

Subsequent sections cover patient class, whether emergent or elective, and how patients are transferred, if necessary, Borowski notes.

[Editor's note: Rita Borowski can be reached at Aurora HealthCare, 2900 W. Oklahoma Ave., Milwaukee, WI 53215. Telephone: (414) 649-5518.] ■

ACCESS FEEDBACK

Get the latest scoop on Joint Commission survey

Few bits of information are as eagerly sought after as those provided by access managers who have recently undergone a survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

With that in mind, **Lynn Weeber,** director of admissions at Hennepin County Medical Center in Minneapolis, offers feedback on the Joint Commission's visit to her hospital in late August. Overall, the survey was the most intense the hospital has had, Weeber says, with a distinct difference in style from previous visits.

Her strongest impression, she says, was of the interviewing skill of the surveyor who spoke with her. "He used a lot of open-ended questions

and knew right where to probe," she adds. "He asked direct, detailed questions, and there was much more of an ability to let [the person being interviewed] speak than in the past. He would identify key words in the response and probe further. You might get pulled into another whole area. He was skilled at getting more than he asked for."

The following questions were asked, Weeber says, either in the admitting interview or in a session attended by department heads:

1. What is your staff vacancy factor? Do I need to be concerned that you are working below budget?

2. Has there been a day, or part of a day, when the emergency department was closed?

3. Do you get feedback from your patients about the admitting process?

4. Does information services support you? Do you get the best, the latest in technology support?

5. Over the long run, you probably will see an escalation in patient days. Are you going to build more beds, and are there plans to "re-operationalize" your capacity?

6. If you are going to transfer patients for insurance reasons (because the insurer asks that they be treated elsewhere), what is your process?

7. Do you have a resource scheduling system (an automated way to make appointments) for clinic visits?

Because a patient had filed a complaint related to the Patient Rights and Confidentiality standard, the surveyor delved heavily into the issue of how complaints are handled, Weeber notes. "He looked for an information disclosure form and asked about policy and procedure in that area. He asked how we inform patients of the process for registering complaints."

One strong lesson she took away from the experience, she says, is that "if you have things in your policy and procedure manual, you need to be following them. Don't have things in writing if it's not your standard to follow them." If the policy says a form will be signed upon admission, she adds, "then you'd better do it. They really want to hold you to what's in your policy."

Rather than examine pre-selected patient charts, she says, the surveyor "went to the nursing floor and said, 'Show me where your charts are,' and picked out some." During the hour she spent with the surveyor, he did not tour the admitting area or talk to registrars.

One interesting development, she says, is that most recently surveyed hospitals she is aware of — including her own — are consistently scoring about 10 points lower on the Joint Commission survey than in the past.

That can be attributed, she suggests, to a new scoring procedure: "When there is [a violation] that crosses over into another standard, they reduce points in both standards."

[Editor's note: Lynn Weeber can be reached at Hennepin County Medical Center, 701 Park Ave. S., Minneapolis, MN 55415. Telephone: (612) 347-2238.] ■

Hospital Access Management™ (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 to 20 additional copies, $239 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editor: **Lila Margaret Moore**, (520) 299-8730.
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@medec.com).
Production Editor: **Terri McIntosh**.

Editorial Questions

For questions or comments, call **Kevin New** at (404) 262-5467.

NEWS BRIEFS

False claims cases settled

The University of California San Diego (USCD) Medical Center and the University of Washington (UW) Medical Center in Seattle will pay the government $8.3 million to settle allegations they submitted false claims to the federal Medicare and Tricare programs, the Department of Justice has announced.

Both facilities submitted claims for surgical procedures using "investigational" medical devices that had not been approved by the U.S. Food and Drug Administration at the time the procedures were performed, reports AHA News Now, an on-line news service of the Chicago-based American Hospital Association. USCD will pay $4.7 million to settle the allegations, and UW will pay $3.6 million. The settlement stems from a False Claims Act lawsuit filed by a former medical device salesman. ▼

New Web site is available for hospital information

QuadraMed Corp. of Richmond, CA, has paired with Health Forum, LLC, a subsidiary of the American Hospital Association (AHA) in Chicago, to provide a more comprehensive Web site for hospital information. This partnership gives QuadraMed's American Hospital Directory Web site (www.AHD.com) select proprietary information from the AHA Annual Survey Database.

QuadraMed has developed its site using Medicare claims, cost reports, and other public-use files obtained from the Health Care Financing Administration in Baltimore. The site enables subscribers to locate any acute care hospital in the United States that treats Medicare patients and track hospital characteristics and services, outpatient statistics, financial reports, inpatient utilization, and costs. Since its inception, AHD.com has had more than 700,000 encounters and a length of stay exceeding eight minutes. ■