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System targets patient throughput with people skills, technology, Six Sigma

Three hospitals have different issues, different strategies

Providence Health System is pulling out all the stops as it focuses this year and next on improving patient throughput at its three Portland, OR-area hospitals, says **Kathy Campbell**, black belt project manager for health services integration.

In June 2005, Campbell says, she assumed a leadership role in answering the question, "How do we improve our process so that we put the right patients in the right beds at the right time?"

A key part of the effort — but by no means the only tool being employed — is the quality assurance and process improvement strategy known as Six Sigma, which has teams led by people who have been trained as "black belts" or "green belts" in the organization.

The Hospital Flow Diagnostic, an electronic tool offered by the Cambridge, MA-based Institute for Healthcare Improvement (IHI) for measuring hospital throughput and activity based on bed turns, also will be used, Campbell adds. **(See related story, p. 111.)**

Each of the three hospitals is doing different things to achieve throughput improvement, because the root cause of the problem might be a little different at each facility, she notes.

Patient throughput, or the efficient use of inpatient beds, is one of three principal areas being targeted this year by Providence Oregon, says **Nancy Roberts**, regional director for integrated performance/ Six Sigma champion. Other areas of focus are labor productivity and patient safety.

An organizationwide initiative called "Operational Excellence," meanwhile, is the thread that runs through all the efforts to "make us efficient, excellent at the work we do," she adds.

"Our Operational Excellence strategies and tools are there to help us

Coming next month: **Special coverage of Hurricane Katrina**

achieve our long-term goals," Roberts adds. **(See related story, p. 112.)**

With the growth in the community served by the health system, has come a large number of under- and uninsured people, which makes throughput improvement especially important, she points out. "We have a mission to serve the poor and vulnerable, so we need to be as streamlined as we can, so we can fulfill our mission."

There currently are four Six Sigma projects that are aimed specifically at improving throughput, adds Campbell, who described them as follows:

- **Length of stay (LOS) for orthopedic patients discharged to skilled nursing facility (SNF).**

Patients on the eighth-floor east orthopedic unit at Providence St. Vincent Medical Center who had hip procedures and had to be discharged to a SNF were found to have a longer LOS than patients discharged home (5.01 vs. 2.45 days), she says.

Facilitating the timely and appropriate transfer of these frail patients, Campbell notes, not only will allow the hospital to better meet patient and family care needs and improve hospital divert times, but it is expected to have a positive financial impact of between $350,000 and $500,000 annually.

The project focuses, among other things, on identifying those patients early in the process and building preprinted order sets around caring for them, she adds.

It has identified a number of factors that can be used to predict LOS variation for these patients, including the day of the week when admission, surgery, and discharge occur; the timing of acute care manager and occupational therapist orders; and when the transfer form is completed.

The goal of the project is to reduce LOS for those patients to an average of 72 hours and a maximum of 84 hours.

While that project employs the extremely data-driven techniques of Six Sigma, Campbell points out, a project on the other end of the eighth floor focuses on communicating with patients at the point of admission about discharge planning.

Those conversations have to do with the expected LOS, whether a certain type of stay might require discharge to another setting or home care service, she says.

Another big piece of the project is working with physicians and nurses to get them to be more efficient at writing discharge orders, adds Campbell .

A third piece is encouraging physicians to do rounds first with patients who are ready to be discharged, rather than the traditional practice of going first to the more critically ill individuals, she says.

This project is people-driven, rather than data-driven, Campbell notes. "Sometimes Six Sigma fits, and sometimes it doesn't."

- **First-case surgery patient in operating room (OR) on time.**

The second Six Sigma project has to do with smoothing out surgery schedules by ensuring that the first surgery case is in the OR on time, she continues. "The premise is that things get

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Editorial Questions

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backed up during the course of the day because they don't start on time."

In 2004, 44% of first-case surgery patients entered the Providence St. Vincent OR early or on time, Campbell notes. The goal is for 75% of elective first-case surgery patients to enter the OR early or on time.

The strategy for streamlining the surgery flow was to make sure there were enough beds for scheduled cases and enough surgery time for the "uncontrollable variation" that comes through the door, she explains.

There is now a ready room available for those emergency cases so the schedule doesn't back up, Campbell adds.

'Bed turn' is at the heart of IHI throughput tool

While Providence Health System has used such methods as measuring length of stay (LOS) and focusing on "discharge by 11" to improve patient throughput, a recent Institute for Healthcare Improvement (IHI) "call around" offered some new food for thought on the subject, notes **Kathy Campbell**, black belt project manager for health services integration.

The call, billed as "What senior leaders need to know about flow," essentially covered an electronic tool that can be used to diagnose an organization's throughput problems, she says.

The tool, known as the Hospital Flow Diagnostic, focuses on "bed turn" as a method for measuring hospital throughput and hospital activity, Campbell says. Bed turn, she adds, can be looked at both with and without adjustment for acuity based on the case mix index.

"[IHI says] the preferred method is to measure bed turn, and when you collect the data, run it through an algorithm," Campbell says. "That tells you whether you have significant delays due to high demand, significant delays due to inefficient use of capacity, or significant delays due to high LOS adjusted for case mix."

After determining whether the problem is LOS-related, there are too many patients who want the beds, or capacity is not being used appropriately, she adds, a facility can focus improvement efforts around its specific issues.

(Editor's note: More information on the IHI throughput diagnostic tool is available at its web site: www.ihi.org.) ■

- **Providence Portland emergency department (ED) to floor transfer.**

The third Six Sigma throughput project focuses on improving patient flow to get patients out of the ED or cared for more appropriately while there, she says.

"We spend a fair amount of time on divert because we can't get certain types of patients out of the ED," Campbell explains. The goal of this project, which is at Providence Portland Medical Center, is to shorten the length of time it takes to get a patient from the ED to the nursing floor.

"They were finding that once they elected to admit a patient, it was taking an hour, on average, to actually get them into the bed," she notes. "They're working to identify the reasons for the backup and what they can do to improve that."

The goal, Campbell says, is to reduce the time between ordering the inpatient bed and the patient leaving the ED to 30 minutes.

"Achieving that reduction on 15% of nonpsychiatric ED patients will more than accommodate a planned admission increase of 406 inpatients, which equates to $1,055,600 in revenue," she adds.

- **Stroke unit process improvement.**

The fourth Six Sigma project concerns the 350 stroke patients treated each year at Providence St. Vincent, 42% of whom have a LOS longer than four days, says Campbell, who notes that work flow inefficiencies cause delays in discharging some stroke patients who are medically ready for discharge.

The goal for this project, she adds, is a 50% reduction in the percentage of stroke unit patients with a LOS of more than four days. The resulting increase in bed capacity on the unit, Campbell says, will allow more stroke patients to be placed there, as opposed to being placed in other hospital units or extending their stay in the intensive care unit.

More on throughput strategies

One of the other initiatives happening in the ED has to do with finding a streamlined way to communicate when the facility needs to go on diversion status, she says. Typically, the access department or the nursing units might learn that the ED is on divert, but they might not know the reason why.

"A Providence research analyst built an electronic means of entering the information and a way to send it out to the key folks, so we know why we're on divert and what we can collectively

do as managers to get off divert," Campbell says.

Another initiative related to LOS, she notes, has to do with its link to secondary behavioral health problems.

At Providence Portland, a nurse practitioner who specializes in behavioral health will be developing a role in which she can support the nursing staff as they deal with patients whose conditions do not fall within the guidelines of mental illness, but whose behavior is interfering with their ability to be discharged.

"Nurses who don't primarily work with mental health patients may not have the skills to deal with behavioral issues, like noncompliance, that might keep patients from being discharged," Campbell says.

Teaching patients how to fish

Rather than being patient-centered, this project is about the nurse practitioner educating nurses in medical-surgical areas, "teaching them to fish," so they can better address these special needs, she explains.

Her intention as she leads the throughput effort is to develop a high-level strategy to tie together operational and administrative improvement objectives. The next step will be to "build tactics for the subcategories to be in line across the board and get a result," she adds.

"One of the things I've heard recently is that [organizations] can get too many projects going, and many of them get diluted," she explains. "Sometimes, different divisions are tackling the same problem and we don't necessarily do a good job of lining up the operational folks with the administrators who oversee the programs.

"From past experience, I know that [operational staff] have priorities that are coming in from various areas in the organization," Campbell says. "When you're the lowest-level staff responsible for filling those [needs], you know you can't do it all. You have to push some things aside and figure out who's going to scream the loudest.

"We need to do a better job of prioritizing and linking those [objectives] together," she adds.

(Editor's note: Kathy Campbell can be reached at kathy.campbell@providence.org. Nancy Roberts can be reached at nancy.roberts@providence.org. Look for information on a Providence project involving outpatient wait times in the next issue of Hospital Access Management.) ■

'Operational Excellence' employs new techniques

Six Sigma, CAP used at Providence

Under the banner of a comprehensive initiative called "Operational Excellence," employees at Portland, OR-based Providence Health System are working to help their organization meet its strategic goals, says **Nancy Roberts**, regional director for integrated performance and Six Sigma champion.

Access issues — including projects aimed at reducing outpatient wait times and enhancing patient throughput — have played a prominent role in the process improvement effort, she says. **(See cover story.)**

Key among techniques being used to improve the efficiency and effectiveness of its business and clinical processes is the quality improvement and process-improvement strategy Six Sigma, Roberts explains. "Many times [to solve a problem] you gather people in a room and say, 'What do we need to do?' That's the expert-driven approach. In Six Sigma, you might start there, but then you look for data to support what you need to do."

A methodology with its roots in the manufacturing industry, Six Sigma has been used in health care only in the past six or seven years, she says. "It's a very vigorous [methodology] to reduce errors in any kind of process. The key elements are the strong use of data to drive decision making and that it's very customer-focused."

Using the concepts "define, measure, analyze, improve, control," commonly referred to as DMAIC, Six Sigma works "in quite a linear way," Roberts explains. "Six Sigma is helpful in analyzing existing processes to find why they're not producing the desired results and analyzing data to determine what you need to fix."

At the same time, Providence is using a change management tool that is designed "to help organizations be better at incorporating and implementing short-term and long-term effective change," she adds. "We've meshed it together with our use of Six Sigma."

Although it's easier to get results in the early phases of a project "when there's a lot of attention on it, a lot of monitoring," Roberts points out, the challenge is in maintaining the change over time.

Providence is using a change management tool

from General Electric called Change Acceleration Process (CAP), but there are a number of others available, she says. "Basically, the theory behind CAP is that in order to effectively move to an improved future state, both people and teams need to work through stages."

It's about "creating a shared need" by asking "Why do we need to change?" and shaping a vision by asking "What does the future look like?" she adds.

"You make sure people are getting feedback on how the new world is working, and some of it is control charts and graphs," Roberts says. "We are, in fact, doing this, and it is having the impact we wanted."

Unlike Six Sigma, she notes, "the CAP model is not linear. You can loop back around when you're doing change management work." ■

Revenue integrity team adds rounds, web training

Accuracy on steady climb since 2000

The University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock has been on an upward trend in registration accuracy since 2000, thanks to continuous tweaking of its education program and improved auditing methods by the access department's revenue integrity specialist (RIS) team.

Registration accuracy is at about 85% now, up from less than 10% in 2000, with a peak score for 2005 of 87%, says **Holly Jones**, CHAM, revenue integrity specialist. "Our goal is 90%."

The latest improvements, she says, include the institution of "RIS rounds," with regular face-to-face audits of access personnel and on-line modules to more efficiently ground staff in the definitions and background part of access training.

With the RIS rounds, team members have adopted a standard practice of doing site visits — at least twice a month — with the employees whose outpatient registrations they are auditing, Jones adds. "That seems to open people up to ask more questions," than if the communication is by telephone or e-mail.

It takes each RIS team member no more than about a half-day to do the face-to-face audits, she says, with each of four staff members auditing between four and 10 employees.

A fifth RIS team member is not part of the rounds, but works at home, completing more than 900 inpatient and emergency department (ED) audits in a 20-hour week, Jones explains. "We just added 10 hours to her schedule, and now she is helping create a fourth day of training."

Central admissions and the ED have their own precept and one-on-one training process, headed by an education coordinator, she notes, but the RIS department provides the audit feedback for those areas. Of the five RIS full-time equivalents, two people audit and train, while the other three do only audits, including the RIS rounds, she notes.

Although inpatient and ED registrations are audited every month, because of the volume and high-dollar accounts, audits of outpatient areas are done randomly, Jones says. "The clinics are numbered one through 38. We plug those numbers into a randomizer web site, and it spits out what we will be doing that month."

RIS team members audit anywhere from 20% to 100% of an area's registrations based on monthly volume, she explains. "We used to do 20% across the board, but we found that with the smaller clinics, there could be only 10 or 20 accounts in a month's time. If there were two errors, that would cut the accuracy rate to 80%, so we wanted to make the process a little fairer for our smaller clinics.

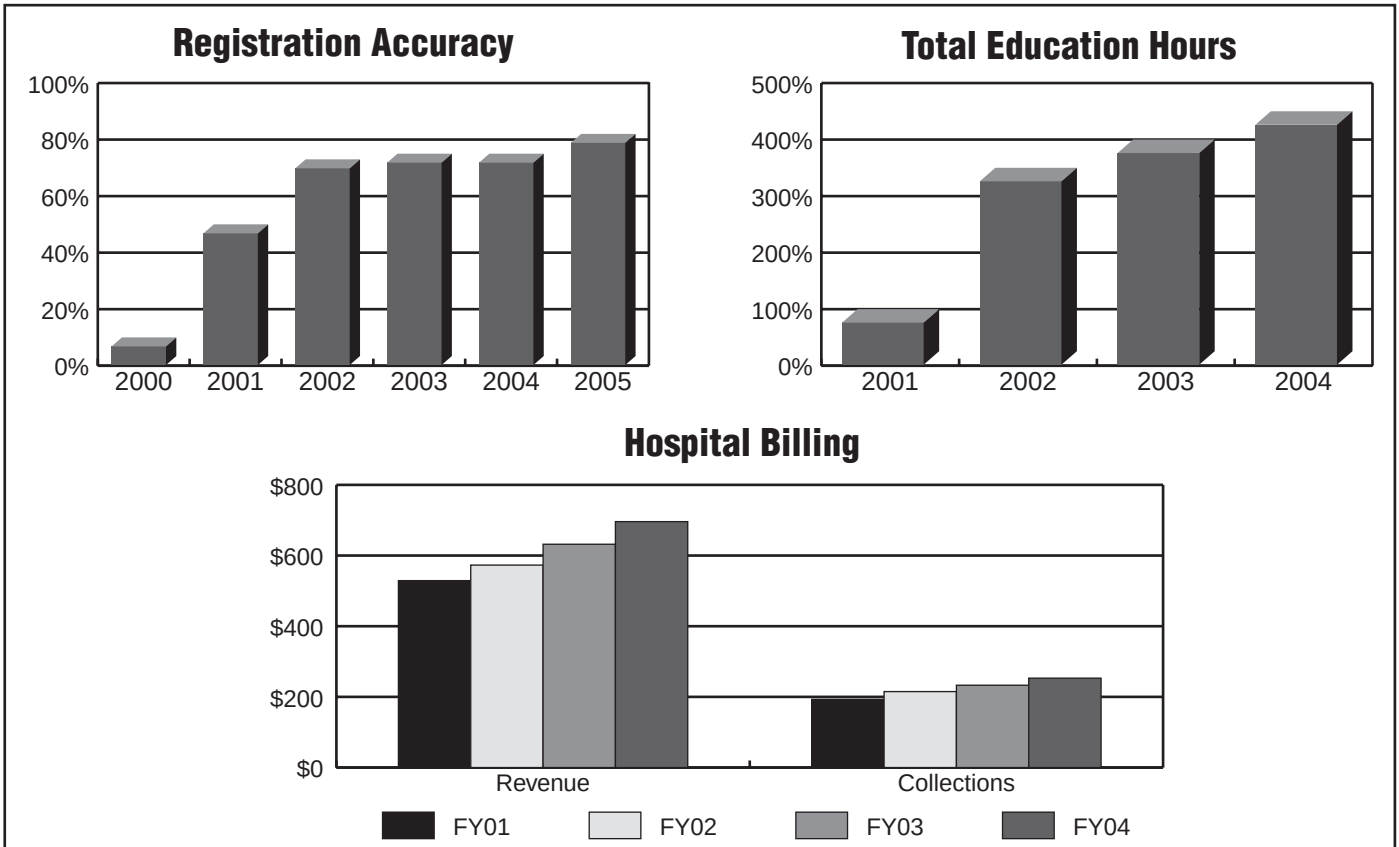
"So now if the occupational therapy clinic is pulled up, for example, every registration gets audited," she adds. "For a larger area, like our cancer center, we will stay at 20% or 25%."

The RIS team member working from home, Jones notes, has been auditing 50% to 60% of the inpatient and ED accounts. Recently, she says, the decision was made to drop that percentage to roughly 15% on straight ED accounts. "The average monthly [ED] volume was huge, and a lot of those are self-pay accounts, so there wasn't a lot of [registration] information to look at. Even at 15%, that's 265 accounts."

The audit process is manual, she says, and is "basically a quality review of that registration to make sure that all the information to make a billable claim is put in correctly. [The auditors] also check the insurance piece, comparing what's in the registration system to what's in the electronic patient folder."

The electronic patient folder, Jones adds, is a program the hospital purchased three years ago that is "basically an electronic medical record."

"There are certain views specific to business functions that all registration staff have access



Source: University of Arkansas for Medical Sciences, Little Rock.

to," she explains. "They can look at an insurance card on-line, so they don't have to keep making copies if the person has been in before. They can ask, 'May I see your insurance card?' and then compare it to what's in the system."

The three on-line training modules have enabled the team to reduce two full days of training to two half days, thus cutting down on the time employees have to be away from their positions, she says. "Everyone seems to be short-staffed, so now they can let [staff] go for a half-day, knowing they'll be back at work for the rest of the day."

After the initial computer training, new registration employees do the first module on their own, and then have the first half-day class, Jones says. In that class, they learn the why behind the way they've been taught to enter the data, get a look at different forms — such as consent forms and living will documents — and are given other general knowledge of their role as access employees.

The second half-day class, she adds, is an overview of all the different types of third-party payers the employee will encounter.

"Then [the new employees] have a 60- to 90-day window, where they're working in their departments," Jones continues.

"We hope they're working with a preceptor, but that's up to the department managers," she says.

After that, the employees come back for a third day of training, Jones notes, which is an in-depth look at the third-party payers they were introduced to earlier, including Medicare, Medicaid, other government insurers, and a full range of commercial payers.

The RIS team is in the process of creating a fourth day of training, Jones says, with more emphasis on precertification, preauthorization, insurance verification, and other financial aspects of the job.

As the rate of registration accuracy has climbed, Jones notes, so has the number of education hours provided to access employees.

The efforts of the RIS team also have been tied to increases in hospital revenue and collections. **(See charts, above.)**

"We work closely with our hospital and physician billing departments," she says. "We have a document called 'Error Criteria,' which are guidelines on registration that we use to audit and that registration staff use as a toolkit as to what constitutes billable errors, those that will stop payment of a claim, and nonbillable errors."

The billing departments approve those

guidelines, Jones says. In addition to the training for new employees, she adds, the RIS team provides monthly inservices, about an hour in length, on such topics as "Denial Reports and How Registration Impacts Them" and "How to Handle Foreign Self-Pay Patients."

To further improve registration accuracy, the team is looking at ways to take access to accounts away from new staff who haven't been through the RIS training within a set time. In the extremely decentralized UAMS environment, Jones explains, some employees who perform registrations do not report to access management, and are on the job after their initial computer training.

"Even as recently as a couple of weeks ago, we were dealing with a lot of accounts where there were major errors with simple fixes," she says. "We saw that they were from people who hadn't been through our training.

"It's a flaw in our system right now that [new registration employees] are able to get technical security access without having to go through [RIS training]. We are trying to track new employees now so we can catch those people."

Part of the challenge is that all of the outpatient clinics have their own managers who report to outpatient administration, "so we're dealing with several managers," Jones adds. "The outpatient administrator has been very helpful with that."

[Editor's note: Holly Jones can be reached at (501) 526-7794 or at jonesshollyr@uams.edu.] ■

'Virtual gathering place' is hospital patient pleaser

'CarePages' result of creator's experience

Several hundred hospitals throughout the country are now giving patients and their families the opportunity to set up "CarePages" that allow them to send updates on the patient's condition over the Internet and receive messages in return.

Swedish Covenant Hospital in Chicago began the program in March, and it has been "a really nice customer service offer," notes **Gillian Cappiello**, senior director of access service and chief privacy officer. "It provides a virtual gathering place, a secure web page that is managed by the patient or a family member or friend.

"The thing people seem to respond to," she adds, "is that in a difficult situation, they don't have to pick up the phone and call everybody; even if it's a happy occasion, such as the birth of a child, they don't want to be gone for two hours making calls. We get a lot of thank-yous for the opportunity to stay in touch when people are far away."

From the perspective of those receiving the updates, Cappiello points out, "it's nice, in times of turmoil, to see how the patient and family are doing without having to ask 50 questions."

The creation of "baby pages" is a common use of the service at Swedish Covenant, she notes, as with the recent birth of a child whose family sent information on the new arrival to grandparents in England.

"[Families] can post photos or write that Uncle Joe had surgery today and is doing fine," she notes. In long-term care scenarios, sometimes it's the patients sending the messages. "[The communications] are exempt from [the Health Insurance Portability and Accountability Act} regulations because it is not the hospital staff doing it."

Hospitals purchase the service from a Chicago-based company called TLContact, and provide it at no cost to patients and their family and friends, Cappiello says. The cost — based on number of admissions — is directly proportionate to the size of the facility.

The CarePages are branded for each hospital, and can be customized to a great extent to include links to the facility's web site, a helpful tips section, or a place to say thank you to the housekeeping staff, she notes.

The Swedish Covenant CarePages, for example, feature a welcome from the hospital's CEO, a way to help with fundraising efforts, and a survey, Cappiello says, asking about the patient's experience with the CarePages and with the hospital, in general.

Included in the survey: "If our service made it easier to communicate your thoughts and feelings, please tell us why," and "If the CarePages service had not been available, how would that have changed your experience?"

TLContact and the CarePages were created out of the personal experience of **Eric Langshur**, the company's founder and chief executive officer**.**

His son Matthew, now 7, had three open heart surgeries, the first when he was only a week old, Langshur says, and his brother-in-law created a web site to keep friends and family informed. "We would leave notes [on the site] about how we were

doing and the surgeries he was undergoing," he says. "In the summer of 1999, we were getting 2,000 unique hits a day. Quite frankly, it was one of those wonderful experiences you have in life. We realized this was the best use of the Internet."

Langshur, an aerospace executive, says he and his wife, a pediatrician, were so enthusiastic about the idea of creating a similar experience for others that they quit their jobs and started the company.

"We had a belief this was a service we had to make available," he adds. "How many of us are presented with something we feel so passionate about in this world?"

While CarePages are available to anyone for free at www.carepages.com, Langshur says, the hospitals that buy the service get the benefits of branding and of building relationships with customers through the welcome pages, patient satisfaction surveys, and other customized features, such as links to their fundraising arms and to on-line gift shops. Faith-based hospitals, he notes, have links to prayer groups that patients can call on.

"The 50 people on average who visit each page become fiercely loyal about the care page and about the hospital providing the service," Langshur says. "We use the loyalty and the reach and the incredible relationship to provide value."

CarePages can be accessed at an Internet terminal in the hospital, at home or work, or on a laptop computer, he says.

The page stays active as long as the family wants it, Langshur adds. "The average length of stay of our customers is four days, but the average duration of a care page is three months. Patients are still healing and convalescing after they get home from the hospital."

The person who is managing the page can shut it down, he says, or after six months of inactivity, the company will send an e-mail asking if the family wants to leave the page up or take it down.

Swedish Covenant currently has three locations where customers can access CarePages, notes Cappiello, and is hoping to add one in the obstetrics area. "Those patients can use [the computer in] the medical library, but it's only open certain hours."

One of the issues her hospital is dealing with, she says, is that if people don't have their distribution lists and e-mail addresses, they can't access America Online or Hotmail to get them because the hospital has restricted Internet access.

"We have to find places that don't violate confidentiality," Cappiello adds.

In view of the recent emphasis on patient safety, TLContact is pushing the opportunity to improve health literacy that the CarePages provide, Langshur says. "We are using the loyalty that the service engenders to deliver patient safety education."

Visitors to the page might, for example, read about the importance of hand washing when it comes to preventing infection, he adds, or be cautioned not to visit the patient if they're not feeling well, or to make sure caregivers wash their hands before entering the patient's room.

"Patient-safety theory is well advanced," notes Langshur, "but there has been no program that has made the patient and the consumer a partner in prevention. We create teachable moments."

(Editor's note: Gillian Cappiello can be reached at gcappiel@schosp.org.) ■

Access takes on the task of rerouting patient mail

'It was a need that arose'

Solutions such as the CarePages designed by Chicago-based TLContact **(see story, p. 115)** are modern-day ways of expressing concern about people who are ill or undergoing surgery.

But while people don't send cards to patients as much as they used to, notes **Gillian Cappiello**, CHAM, senior director of access services at Swedish Covenant Hospital in Chicago, there is still a sizable flow of personal mail arriving at hospitals that must be dealt with.

With increasingly shorter lengths of stay, she adds, much of it arrives after the person has been discharged. At Swedish Covenant, Cappiello notes, the access department has taken on the task of rerouting that mail to its intended recipient.

"It was a need that arose," she says. "It originated with a call from somebody who had sent a card to a person who never received it. The caller said, 'What do you do with it?'"

Realizing a need was there, Cappiello's response was, "We can help with that — it's a pretty easy thing for demographic people to do."

Now, she says, "rerouting mail is one of our big things. The mailroom [staff] check the patient census each day to see which unit [a piece of mail] goes to and puts it in that box. If the name is not on the census, they give it to us. We find out where the patient was discharged to and mail it there." ■

Reader seeks listserv: Is there a forum for access?

Question: Are there any listservs for admitting/access departments?

— Paula Caster, admitting/communications supervisor at Ridgecrest (CA) Regional Hospital

Answer: An informal search by *Hospital Access Management* turned up no listservs, or electronic mailing lists, specifically designed for access professionals, other than those created by organizations exclusively for their members.

The National Association of Healthcare Access Management (NAHAM) in Washington, DC, for example, offers a members-only "Access Forum," described on its web site as "an interactive bulletin board where members may share tips and resources, ask questions of one another, and help fellow members solve problems or take a new view toward a particular situation."

Many state affiliates of NAHAM, such as the North Carolina Association of Access Management, also have group e-mail lists that members use to exchange questions and ideas.

The Healthcare Financial Management Association offers its members separate special-interest group forums that focus on health care compliance, managed care, and patient financial services (PFS). The PFS forum addresses such business office issues as revenue cycle improvements, compliance, billing and coding issues, and data standardization and privacy.

The University Health System Consortium, based in Oakbrook, IL, has a service for its members called "Interactive Communication Sharing."

Finally, access professionals may find useful the electronic mailing lists offered by Medicare, particularly "HIPAA Outreach." While these lists are not tailored specifically for access, they may be helpful with certain issues.

[Editor's note: If you are aware of other electronic mailing lists that may be of benefit to access managers, please contact Hospital Access Management *Editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.]* ■

Court ruling underscores sanctity of triage systems

EMTALA requirement cited

Hospitals may safely upgrade the patient acuity classifications of their emergency department (ED) triage systems, but they cannot downgrade them, for fear of violating the requirements of the Emergency Medical Treatment and Labor Act (EMTALA).

That's the reaction of EMTALA specialist **Stephen A. Frew**, JD, to a recent decision by the U.S. Court of Appeals for the First Circuit, which ruled that deviation from the triage classifications of a hospital may state a cause of action for violation of the law's screening and stabilization requirement.

The appeals court overturned a lower court order dismissing the case of *Edgardo Jose Cruz-Queipo, et al v. Hospital Espanol Auxilio Mutuo de Puerto Rico.*

According to the court opinion, the plaintiff alleged that the patient presented at 4 p.m. with complaints of chest pain, arm pain, and wrist pain, which was a Level II complaint under the hospital's triage classification system.

The patient was triaged by a physician as Level IV (lower priority) for back and muscle pain, and chest pain complaints were not documented in the record at any point.

The patient received an exam by another physician at 5:30 p.m. and an electrocardiogram and cervispinal X-ray were performed. The patient later was discharged with a diagnosis of thoracic outlet syndrome.

The following day the patient returned to the hospital ED with severe chest pain radiating to his left arm and jaw. He was diagnosed with an acute myocardial infarction and remained in the cardiac care unit for a week and then was transferred for a coronary artery bypass graft.

The patient allegedly sustained permanent damage that could have been prevented by timely diagnosis and treatment on the first visit.

The hospital conceded that if the patient had complained of chest pain, a different treatment protocol would have been required.

Conflict of evidence

A conflict of evidence on the issue of whether the patient had complained of chest pain required reversal of the summary judgment for the hospital and return to the trial court for a jury trial, according to the court's ruling.

Frew, a risk-management attorney and web site publisher — www.medlaw.com — notes that in its ruling, the court went on to say that "the plaintiffs assert that if we accept that Cruz complained of chest pains during his Aug. 31 visit, we must also conclude that the hospital had a duty to stabilize the heart condition that culminated in a heart attack on Sept. 1. We agree.

"Cruz's placement in Category IV despite a complaint of chest pains thus marked a departure from the hospital's standards, which set the parameters for an appropriate screening," the court stated.

In a footnote to the ruling, the court pointed out that the hospital "claims the patient's heart condition was attributable to his 'inability to adequately care for his physical condition' by controlling his cholesterol and blood pressure, rather than to any action or omission of the hospital."

Describing that argument as a "nonstarter," the court noted that hospitals generally do not cause the emergency conditions that they are called upon to stabilize under EMTALA.

"That does not mean, however, that a hospital's failure to stabilize a condition bears no causal relationship to the damages suffered by a patient as a result of a deterioration in his condition that could have been avoided by stabilization," the court added.

The case must return for trial, Frew explains, and whether or not the patient complained of chest pain and was improperly triaged is still under contention.

Even so, he emphasizes, the case supports the standard Centers for Medicare & Medicaid Services (CMS) practice of citing hospitals for violation of their own policies and procedures, in particular for failing to note triage categories and selectively downgrading patients to lower classifications than specified in the policies.

"The initial reaction of many facilities," he adds, "may be to suggest that they will remove classifications or make them entirely subjective. CMS, however, has repeatedly cited [hospitals] for lack of clear triage classification standards and practice.

"It is particularly salient," Frew continues, "that the deviation from the triage system was not the result of a nursing judgment, but occurred based on a physician judgment.

"It is not uncommon to encounter the assumption in hospitals that the physician can override the triage system," he adds. ■

Grievance process is clarified as CoPs revised

Changes already in effect

The Centers for Medicare & Medicaid Services (CMS) has issued revisions to its interpretive guidelines for the hospital conditions of participation (CoP) in Medicare, including clarifications on how patient grievances should be handled and when a billing complaint is considered a grievance.

The revisions to the grievance guidelines, which became effective Sept. 19, 2005, are found in Section 482.13, where the conditions specify: "The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance."

Among other issues, the section addresses who can handle patient complaints and when complaints should be categorized as grievances; the requirements for responding to patient grievances; and when a grievance is considered resolved.

Changes to the grievance definition and process were suggested earlier in the year by the Society for Healthcare Consumer Advocacy, an American Hospital Association (AHA) personal membership group for health care consumer advocate professionals.

The revised guidelines define a patient grievance as "a written or verbal complaint [when the verbal complaint about patient care is not resolved at the time of the complaint by staff present] by a patient, or the patient's

representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital CoP, or a Medicare beneficiary billing complaint related to rights and limitations provided by Title 42 of the Code of Federal Regulations, Part 489."

Clarifications

Some of the clarifications are as follows:

- "Staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location to resolve the patient's complaint.
- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution then the complaint is a grievance. A complaint is considered resolved when the patient is satisfied with the actions taken on his or her behalf.
- Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 is considered a grievance.
- A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs. An e-mail or fax is considered "written."
- Information obtained with patient satisfaction surveys does not usually meet the definition of a grievance unless an identified patient writes or attaches a written complaint on the survey and requests resolution. If the patient does that but without requesting resolution, the hospital must treat the complaint as a grievance if it would usually treat such a complaint as a grievance.
- Any verbal or written complaints regarding abuse, neglect, patient harm or hospital compliance with CMS requirements is considered a grievance.
- Whenever patients or their representatives request that their complaint be handled as a formal complaint or grievance, or when the patient requests a response from the hospital, the complaint is a grievance and all the requirements apply. ■

NEWS BRIEFS

Claims must comply with HIPAA rules

Beginning Oct. 1, the Centers for Medicare & Medicaid Services (CMS) will no longer process electronic Medicare claims for payment unless they comply with the Health Insurance Portability and Accountability Act (HIPAA).

Noncompliant claims will be returned to the filer for resubmission as compliant claims. The decision affects claims for services provided under fee-for-service Medicare, ending a portion of the CMS HIPAA contingency plan in effect since Oct. 16, 2003, under which Medicare continued accepting noncompliant electronic claims after the deadline.

As of June 2005, only 1.45% of claims from hospitals were not HIPAA-compliant, CMS said.

Although the contingency continues for other electronic health care transactions, CMS said it expects to end the contingency plan for those transactions in the future, beginning with the remittance advice transaction. ▼

Heart attack patients wait longer in off-hours

Heart attack patients who arrive at the hospital during off-hours and on weekends wait longer for artery-opening procedures, such as angioplasty, decreasing their odds for survival, suggests a recent study reported in the *Journal of the American Medical Association*.

The study found that the after-hours patients waited an average of 116 minutes for percutaneous coronary intervention procedures, compared to an average of 95 minutes for patients arriving between 7 a.m. and 5 p.m. on weekdays.

The study's authors attributed the delay to longer wait times at catheterization laboratories, which few hospitals staff around the clock.

They suggested that hospitals consider 24-hour staffing of catheterization laboratories or regional

arrangements in which off-hours patients are taken to facilities with continuous catheterization lab coverage and faster treatment times.

The article noted, however, that the first approach would have resource implications for hospitals, and that the second approach could increase transportation times for some patients, potentially offsetting any improvements in treatment times.

The authors, who used data from a national heart attack registry and the American Hospital Association's annual hospital survey, also compared wait times for clot-busting drugs and found no appreciable difference, with both groups waiting slightly less than 35 minutes for the medications. ▼

Registering volunteers topic of disaster report

A report by the American Hospital Association (AHA), which summarizes hospital recommendations on an advanced registration system for health care workers interested in volunteering in disasters, has been published by the Department of Health and Human Services' Health Resources and Services Administration.

Federal law requires that all states and territories in the United States put into place a registration system that will enable hospitals to quickly verify the identity, licensure, and qualifications of volunteer physicians, nurses, and behavioral health personnel who step in to help in disaster situations.

The report stems from a meeting of the AHA and teams of representatives from the 10 states involved in a pilot of the program, including state department of health staff, state hospital association representatives, and hospitals.

Among the participants' recommendations were that states should work with the health care community to identify and close gaps in legal protections for hospitals using volunteers in emergencies, and the federal government should work with states to ensure registration systems are interoperable and include sufficient information to be of value to hospitals.

Participants also called for the development of a web-based tool summarizing state workers' compensation laws and a tool summarizing license reciprocity agreements across states.

The meeting was the second of four planned between 2004 and 2006 to discuss the Emergency System for Advance Registration of Volunteer Health Personnel and its implementation. ▼

'Most wired' found to have better outcomes

The country's top tech hospitals also have better outcomes, suggests an analysis performed in connection with the release of a list of the nation's 100 "most wired" hospitals.

The list, which was based on 502 surveys representing 1,255 hospitals, identifies hospitals and health systems that have made significant investments in health information technology, most notably to address quality and safety, assist physicians with orders, and conduct clinical activities.

Those listed "have, on average, risk-adjusted mortality rates that are 7.2% lower than other hospitals, even after controlling for the size of the hospital and teaching status," according to the journal *Hospital & Health Networks*, which compiled the list.

While the new survey does not establish a cause-and-effect relationship between IT use and improved outcomes, the journal said, it does show technology can play "an important role in quality." ■