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Use latest technology, creative thinking to tackle challenges of ED overcrowding

Tracking system, good use of data provide answers at Wake Forest

With a recent study highlighting the lack of surge capacity in the nation's emergency departments (EDs) and concerns about how health care facilities would respond in the event of pandemic flu, it's imperative that hospitals find meaningful patient throughput solutions, says **James Bryant,** director of emergency and transport services at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

The American College of Emergency Physicians' (ACEP) "National Report Card on the State of Emergency Medicine," which gave the emergency medicine system of the United States as a whole a grade of C minus, was "a wake-up call for the national health system," Bryant adds. "This is a challenge to make our system more flexible."

At least part of the response to that challenge lies in technological innovations, such as ED tracking systems that identify where patients are in the process and where the bottlenecks are, he says. With hospitals that have such systems, Bryant notes, the question becomes, "How are they using those data?"

Wake Forest put an electronic tracking system in its ED two years ago and began to see, among other things, that patients who had been triaged were sitting in the waiting room even though there were empty beds in the treatment area, he says.

"If there is a ready bed, patients should move directly from triage to the ready bed," Bryant says. "Putting them in the waiting room for 10 minutes just causes delay. That was the way we'd always done it, but it's not a good model. If you've got a bed, put the patient in it."

With the tracking system, everyone on staff sees the same information, he says. In the past, Bryant adds, the triage nurse might not have known what was happening in the back, and the charge nurse might have been unaware of the situation in the waiting room.

"If I don't know there are 15 people waiting to be seen, I may not be in as much of a hurry," he points out. On the other hand, if the charge

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nurse is aware of that crunch, and sees that a person is waiting for discharge, Bryant notes, "she realizes that if she just goes over and [discharges the patient], she could have a ready bed."

Even newer technology — now in place at only a handful of facilities — would allow hospital staff to place transmitters on patients and look at a screen and know exactly how they're moving through the department, he says.

The process is the same as that used by the retail industry to create automatic inventory tags, Bryant notes. "Price is still prohibitive, but we're looking at the technology."

Patients wearing these radio frequency identification (RFID) bracelets, he adds, can be greeted by name, for example, as they approach the imaging area: "Hello, Mrs. Jones. We were expecting you."

"Bar codes are really popular, and this is the next evolution of bar codes," Bryant says. "Patients would still get a bar-coded armband, but they would also have an RFID band."

In terms of patient safety, he adds, there would also be RFID tags on blood and medication, so that any mix-ups would be flagged.

Diversions 'a symptom'

The ACEP report points out in its listing of national emergency care concerns that only 10 states currently collect data on the frequency with which hospitals go on diversion status, or "divert" ambulances, because they are unable to handle any additional emergency patients.

While diversion information is "very important," Bryant says, "hospitals are starting to catch on that if hospital A goes on diversion, hospital B almost has to go on diversion, and so on; it just shifts the burden."

Wake Forest has a "no diversion" policy, he adds, partly because it is a level one trauma center.

"Each hospital has to learn how to respond to its surge," Bryant says. "Diversion is a symptom of the problem." The report, he says, makes note of the need for surge capacity in the critical time between when a disaster occurs and when state or federal resources can be mobilized to respond. That need was highlighted by the Hurricane Katrina disaster.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized the situation as "more than just an ED problem," Bryant notes, and has instituted standards requiring hospitals to have a plan in place to address patient flow. **(See related story, p. 41.)**

At Wake Forest, where an ED designed for 56,000 visits a year is accommodating 76,000, Bryant says, an ED holding unit is helping facilitate patient flow.

"Part of the rationale is that many patients are here for several hours just because of certain testing procedures; so we created a 10-bed holding unit on the sixth floor," he explains. "If patients are going to be [in the ED] for multiple hours, we move them there so we can bring in more acute patients."

The effort has been successful enough, Bryant

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notes. Plans are in place to expand the hours of the holding unit from 12 hours a day, six days a week to 24-7, probably in January 2007.

"It's been a real positive," he says. "It also offers more opportunities for the ED staff. If you're an ED nurse, the holding unit can be a little bit of a break. We can float staff, so it's a big staff satisfier."

'Quick reg' key to improvements

Innovations on the front end of Wake Forest's ED operations also have proved fruitful in enhancing patient flow, Bryant says. After patient satisfaction surveys showed that people were dissatisfied because they felt they were not acknowledged upon their arrival in the ED, the hospital took another cue from the retail business.

"We put in a patient greeter, who takes the patients' names [immediately] and puts them into the system, along with the complaints," he explains. "The triage nurse looks at the screen, sees the complaints, and takes the most urgent first.

"Initially our goal was for the patient to see the triage nurse within 15 minutes of arrival, but now we've gotten it down to four minutes or less," Bryant says. "We were able to use the data created by the greeter, which include how long the person has been waiting."

Again, those data also are seen by the charge nurse who — seeing that five people have come in at once — sends someone out to help, he adds.

Before the greeter position was created, notes **Charlynne Lynch,** CAM, manager for ED registration/financial counseling, patients checked in at the central registration desk before going back for treatment.

"[The greeter] has certainly expedited the process, because [patients] no longer have to wait on us," she says. "In the past, if the triage nurse was busy, there was no one there to greet the patient and no coordination at the front desk."

The patient greeter is in place around the clock, and reports to the nursing department, Lynch adds, although there has been some discussion of switching the position to the registration department.

The greeter, she says, goes into the admission/discharge/transfer (ADT) system and does a "quick registration," starting with a patient name search in which he or she enters the patient's last name, first name, and middle name, and asks to see a Social Security card or driver's license for identification.

If the search does not locate a medical record for the patient, Lynch notes, the greeter asks for the person's date of birth in order to create a new record.

Additional elements that may be entered during the "quick reg," she says, but don't have to be, are gender, race, mode of arrival, attending physician, and patient location, as well as ED, pediatric ED, or "fast track," a lower acuity area that is open from 11 a.m. to 11 p.m.

Registrars look at the registration later, after patient care has been initiated, and verify all the components, Lynch adds.

ED "quick reg," an innovation that came about around the same time the electronic tracking system was implemented, got its start when ED staff and leadership were looking at a way to get patients on the tracking board without having to wait on registration, she explains.

"There are only a few registrars [to go around], but we have nurses or other clinical staff who are with the patient pretty fast," Lynch says. "Even one of the physicians said we don't have to have a [registrar] to be there immediately at all the beds."

Although she personally wrestled with the idea of relinquishing control of this piece of the registration process to clinical staff, the results speak for themselves, Lynch says now. "It works."

She says she has been asked by access colleagues, "How comfortable are you giving that authority to nurses? Aren't you worried about duplicate medical record numbers?"

While she did have concerns about duplicates, Lynch explains, she was confident in the ED leadership's commitment to accuracy. "They also don't want any adverse effects. They've done an excellent job, and it's noticeable to us as staff members that the flow is much quicker.

"Now the patients are rapidly put in the system, so the information is captured as soon as they get there," she adds. "Even in the back, if the patient comes in by ambulance, the nurse does the quick registration. We gave [nurses] the capability to do what we used to do. Now they're not waiting on registration at all. We're not in that flow, although we are definitely the support system."

The medical records department worked with registration staff in training both nurses and unit secretaries to do the quick registration, Lynch

Empowering staff creates ED throughput solutions

'Identify problem, suggest a change'

One of the most effective strategies for enhancing ED throughput at Wake Forest University Baptist Medical Center in Winston-Salem, NC, has been to create small working groups to address specific problems, says **James Bryant**, director of emergency and transport services.

"We identify the problem, suggest a change, and get a small group of staff members together to do a trial," he says. "We depend on them to tell us what works and what doesn't."

The reasoning, Bryant adds, is that "we work with very talented people, and we trust and expect them to do a good job. All we have to do is say, 'This is our goal and here are our resources.'"

An example of this theory of employee empowerment, he says, was a "door to balloon" project aimed at reducing the time it took to get a patient complaining of chest pains to the cardiac catheterization lab.

"We knew that the time it takes to get a patient with a suspected heart attack from the ED to the cardiac catheterization lab for an angioplasty was a [measurement] that was being monitored by the Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare and Medicaid Services."

In late 2004, when the project started, Wake Forest had an average "door to balloon" time of 180 minutes, Bryant notes, and set a goal of 120 minutes.

A team was assembled that included a registrar, a nurse, a nursing assistant, a member of ED administration, and an employee from the cath lab. After looking at the entire process and identifying the bottlenecks, he adds, the team developed a standardized procedure for such patients.

"[The team] came up with a checklist, standardized orders, and created a box with the special equipment needed for the cath lab," Bryant says. When a person complaining of chest pain presents at the ED, he adds, the patient is taken directly to an ED bed, along with that box, which also includes all the forms that will be needed.

Eventually the team was able to get the "door to balloon" time down to a low of 67 minutes, Bryant says. "It's been below 90 minutes for the past four months."

In the past, those patients might have seen a triage nurse, been placed in the waiting room for a few minutes, and then taken back to a bed, he adds. "Different people did it different ways, but all that added up to delays. We've eliminated that variability and we get people upstairs [for angioplasty] faster."

Before nurses were empowered to do quick registrations in the ED **(see cover story)**, notes **Charlynne Lynch,** CAM, manager for ED registration/financial counseling, clinicians had to wait for a registrar before certain treatment steps — such as ordering an electrocardiogram — were taken.

"It's not that [registration] prevented patients from being treated, but it was just [a matter of] at what point the medical record was generated," she says. During an earlier effort at facilitating the door to balloon process, Lynch adds, if the nurse knew she had a patient fitting those criteria, she had to call the registration department, provide the person's name and date of birth, and have someone run down the medical record number.

"The continuity of information wasn't as smooth," she says. "The [clinician] might have had to start the procedure without having the medical record number at that moment because it was left up to the registrar to get that piece." ■

notes. "We modified our Healthquest system, a McKesson product, to allow the search for a medical record number to happen on a 'quick reg,' and to include only the fields that concern the clinical staff.

"If the nurses do select a good medical record number, they don't have to go through the patient name fields," she adds. "[The system] will go straight to the fields they need to complete. It's not requiring them to do everything a registrar would do."

The one exception to the ED quick registration process is that trauma patients still are registered by her department, she notes. Registration typically receives a call in advance of a trauma patient's arrival, Lynch says; but even if a patient is already in the ED and then upgraded to trauma status, registrars are still notified and handle the registration.

"We have trauma packs with new medical record numbers," she adds. "We coordinate the trauma packs and we maintain a log for trauma registry. We want everything at the bedside when those patients arrive."

(Editor's note: James Bryant can be reached at jbbryant@wfubmc.edu. Charlynne Lynch can be reached at chlynch@wfubms.edu.) ■

Assess patient flow; Use data to improve

That's advice of JCAHO director

The patient flow standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are "about planning," says **Carol Gilhooley,** director, survey methods development, in the division of standards and survey methods for the Oakbrook Terrace, IL-based agency.

"What we ask organizations to do is assess the flow from admit to discharge, collect data, analyze that data, and turn it into information that can be used to improve performance," Gilhooley adds. "Organizations need to step back and look at [ED overcrowding] as a hospital-wide problem.

"Frequently, there are problems with wait time," she notes. "It could be a problem in the ED, but it might be because of slow discharge and because surgery and the ED are competing for those beds."

JCAHO suggests collecting indicators for key support services to get at solutions that are not the most obvious, Gilhooley says. "Housekeeping may not be turning around rooms fast enough, or lab values may not be coming back quickly. It could be patient transport. Maybe it's the staffing in the admitting department.

"It's really an input, throughput, output situation," she says. "Match output to input, or otherwise there is a bottleneck. So look at the bottleneck and see what you find out."

Another important consideration regarding patient flow is that once the decision has been made to admit an ED patient, that individual is defined as an inpatient, Gilhooley points out. "All assessment and care protocols for inpatients are applicable.

"Say the person [waiting for a bed] is supposed to be admitted to the intensive care unit," she adds. "Do they have access to the same technology if they're on a cart in the hallway? Do they have privacy, access to a call bell? Is the appropriate physician — perhaps a specialist — available to care for that patient?"

JCAHO also expects the hospital to plan for the care of "borders" — patients who are waiting for treatment, for diagnostic results, or to see a specialist, Gilhooley says. "Those kinds of individuals can add to a bottleneck situation."

A subject JCAHO surveyors are likely to address with hospital leadership is whether resources are provided to manage those patients, she says. A point to note would be, "Does leadership take action based on those data?"

While JCAHO's focus has always been to protect the quality and safety of care, the agency is now spending more time on the scene observing, Gilhooley says. "Before 2004, we spent a significant amount of time on policies and procedures, which were the promise of execution. Now we're looking at whether the promise is really implemented."

Post-9/11 emphasis

Since Sept. 11, 2001, emergency management has been particularly important, she adds. Surveyors might, for example, ask any hospital employee such questions as, "What do you do? Who do you report to? What are your responsibilities when the [hospital] implements its emergency management plan? How were you trained?"

A likely question for access staff, Gilhooley says, is "What do you do when the systems are down?"

"Our standards require two drills a year," she notes. "One is a drill when there is an influx of patients. I think [surveyors] might ask, 'Do you use temporary registration procedures? Do you have temporary triage areas and procedures?'"

Surveyors may select a scenario and ask a staff member to pretend that the hospital has just experienced that event, Gilhooley adds. "[The surveyor] may go to all the areas that would be impacted and say, 'Do you know what to do?'"

The whole process involved in the transition, from paper to electronic medical records, is an "up-and-coming" area that JCAHO will focus on, she says. "That transition [period], when some will be using both [kinds of records], is a vulnerable time. We're looking for processes designed to minimize those vulnerabilities."

JCAHO has in the works a task force on health information technology that will address those

kinds of issues, Gilhooley adds.

Easing communication challenges

Another important JCAHO focus has to do with eliminating the barriers to patient care sometimes posed by communication issues, she says.

"We've got a lot of standards that apply to language and culture," Gilhooley points out. "We want to ensure that patients' values and beliefs are respected, and [enable] patients' involvement in their own care."

While some of the emphasis is on the provision of adequate interpreter and translation services, she notes, the communication challenges don't stop there.

"What we're finding when we look at language issues, is that people who speak English are also having trouble understanding," Gilhooley says. "It's not just the health care provider imparting information; it's whether the other person understands."

Because so many medication errors occur at discharge, she adds, JCAHO surveyors are now asking questions designed to make sure the discharge conversation has actually been a two-way communication.

"They try to talk to a patient who has already been given discharge instructions if the person is still there," Gilhooley says, "but they can also ask to call and talk with one who has been recently discharged.

"We do have medication reconciliation as a new national patient safety goal," she notes. The idea is to know what medications the patient is coming into the hospital with and which ones they're supposed to be leaving with, Gilhooley adds. "Somebody should be looking at that and managing the whole patient." ■

Training puts team leaders on same page with project

Effective communication emphasized

With eight design teams set to participate in a wide-ranging revenue cycle initiative at the University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock, the next order of business was to ensure that all of the players were starting at the same baseline, says **Holly Hiryak,** RN, CHAM, director of hospital admissions/patient access and one of the two project leaders.

"We felt like in order for the teams to function fairly consistently, they all needed to be operating at the same level," she adds. "We wanted them to use the same form of communication, and the same logic in [determining] the role of the team leader."

With that end in mind, Hiryak says, she and fellow project leader Jeri Garland from the information technology (IT) department, along with human resources trainer Melissa Johnston developed a leadership training program. It was presented in a day-long session to the team leaders — one for each of seven design teams, and three for the design team for the scheduling component, the largest part of the project.

"[The training] was well-received," she adds. "It gave team leaders a better idea of why they were in the role, what was expected, the level of commitment. They also began forming a bond through knowing who else was 'in it with them,' so to speak."

The team leaders will be part of a project workflow group that will help facilitate the project, Hiryak notes. "They will meet — probably once a week once we're up and going — to address any interface or cross-function issues that might arise. [The training] will put the tools in their hands to help them do that."

It was important, she says, that design team leaders came to the project with a strong understanding of the tool to be implemented, or the process involved. "The leader for the Interface Link Engine team doesn't understand the product [a tool that allows users to scan documents at the point of access], but she understands the processes that will be impacted by the product.

"I can educate her on how the tool works," she adds, "and once she understands that, she will understand how it will help in various areas."

Other design teams, Hiryak explains, cover tools and functions regarding pre-registration/registration; billing; scheduling; front-end verification of patient demographic and credit data; upfront checking of medical necessity; and real-time verification of insurance coverage status.

Team dynamics addressed

The leadership training session began with general comments about the ELVIS Project (the

Charter promotes clarity, focus to project teams

It avoids the question, 'Why are we here?'

Each team participating in the ELVIS Project at the University of Arkansas for Medical Sciences (UAMS) Medical Center will have a charter defining the team's mission, scope of operation, objectives, and time frames.

"A charter provides clarity and start-up direction, focuses resources, and empowers the team," says **Holly Hiryak,** RN, CHAM, director of hospital admissions/patient access and co-leader of the project. "It avoids the floundering of 'Why are we here?' The team is more likely to own the project and the solutions."

While the charter may be created by top management or by the team itself, she stresses, it must have the endorsement of top management.

The charter should include a one- or two-line purpose statement explaining why the team was formed, Hiryak adds, and that statement should align with the organizational vision or mission. The document should outline measurable objectives, with provision for the use of benchmarks, evaluation, and milestones throughout the project, she says.

Charter Responsibilities

- Must be clear and aligned with organizational goals.
- Challenging objectives to warrant team's work and expertise.
- Scope of authority must be defined.
- Must provide team direction.

"It's about *what* the team needs to achieve, not *how,*" she emphasizes. "If you try to tell [team members] how to achieve their goals, they wonder why they are there."

A charter gives the team boundaries within which to work, adds Hiryak, who wrote a set of guidelines for developing a charter. **(See excerpt, this page.)** "You have to set boundaries to avoid energy-depleting activities. You don't want to have to say, 'Oh, no, that's not what we intended.'"

The charter also sets criteria so that managers are able to allocate resources to the team, she says. "You want to give them something that indicates the commitment of time we're talking about, the action commitment expected of each team member."

Perhaps most significantly, Hiryak says, the document includes "top management's commitment to the project in writing." ■

acronym is for eligibility, verification, insurance, and scheduling) and continued with information about team dynamics, Hiryak says.

For example, creating a successful team experience, she notes, requires that members do the following.

- Establish team norms
- Understand the goals
- Understand the roles
- Recognize and manage the forces
- Have a problem-solving process

To understand team goals, participants looked at these questions:

- What are our goals?
- What are our milestones?
- Are the goals clearly stated or written?
- What is the action plan for achieving the goals?
- What resources do we have to achieve the goals?
- How are we going to celebrate along the way?

Effective communication was covered in the leadership training session, Hiryak says, including the importance of creating a clear, well-organized message by beginning and ending with a summary statement.

The message should deal with facts arranged in an appropriate manner, omit unnecessary details, and not contain too much information, participants were told.

They also received instruction on "listening to communicate," she explains, which is difficult because people often reject or overlook information that conflicts with preconceived notions, and because our minds are capable of processing information quicker than a person can speak.

Managing expectations

One of the key reasons team leaders need to learn to communicate appropriately, Hiryak points out, is so they can "manage expectations" regarding the project and "not give a false sense of what can or can't be done."

There is a tendency with a project of such scope and magnitude to convey the idea that it will be the "end all and be all," she says. "While this is going to solve a lot of our problems, help with patient flow, and ultimately improve patient satisfaction, it is not the one and only. There will be process and people changes [that need to take place].

"So managing the expectations of the end users — physicians or whoever else they might be — is important," Hiryak adds.

While team leaders will compare notes with their counterparts on various facets of the ELVIS Project at the weekly project workflow group meetings, participants will use SharePoint, a Microsoft document management tool, to provide ongoing updates, she says.

"This is where we are placing all of the documents related to this project," Hiryak adds. "When we are communicating with one another, this is the one place we can tell people to look to find information about the project. It is the place where we will list outstanding and completed tasks, and an events calendar, as we launch different parts of the project."

The events calendar also will include the dates when key people will be away from work, she notes, to avoid the scheduling of a meeting with the vendor at those times.

Using SharePoint, Hiryak explains, a member of the scheduling team, for example, would be able to upload and view documents concerning that part of the project. But if that individual just wanted to see what the ILE team was working on, he or she would have view-only rights, she says. "He could look at minutes, work plans, who is on the team, as well as templates, project governance, and the charter for each team." **(See related story, p. 44.)**

"If a team is dealing with a certain issue," Hiryak adds, "maybe they'll want to take a cruise on SharePoint to see if other teams are having some of the same concerns."

*(Editor's note: **Hospital Access Management** will publish periodic reports on the progress of UAMS Medical Center's ELVIS Project. The first article appeared in the March issue. Holly Hiryak can be reached at HiryakHollyM@uams.edu.)* ■

GUEST COLUMN

Patients embrace use of kiosks for check-in

Payment option is next step

By **Gail Mitchell**
Director of Regional Access Services
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*(Editor's note: In this second segment of a two-part series, Gail Mitchell describes two access initiatives designed to simplify the registration process: check-in kiosks and centralized pre-registration. The first segment, by Rebecca Coplin, dealt with the infrastructure the organization has in place to ensure process improvement, including Six Sigma training and the creation of the Seamless Access department. It ran in the February 2006 issue of **Hospital Access Management**.)*

In implementing self-service kiosks, the first of two Providence Health System initiatives aimed at improving revenue cycle and patient satisfaction scores, our goal was to reduce wait time in our outpatient areas by providing the option of self check-in.

The project team decided to pilot a kiosk with pre-registered patients receiving mammograms. Providence then started a relationship with the vendor Galvanon (now NCR) to build our model kiosk and determine how it would function and present to our patients.

The result is a custom, sleekly styled product that interfaces with our host health information system, presents aesthetically as state-of-art technology in our clinical areas, and provides a final product to our patients that is tailored to meet their needs and our goal of streamlined patient processing.

Use of the kiosk has a qualifier: The patient must be pre-registered prior to the date of service. Patients are informed about their ability to use the kiosk to check in at the time of pre-registration. To date, between 60% and 70% of patients who qualify actually use it on the day of service.

Patients who have been informed about the

process can approach the freestanding chrome kiosk and either swipe a card with any magnetic identifier or type their name using the onscreen keyboard — much like an airport kiosk check-in application.

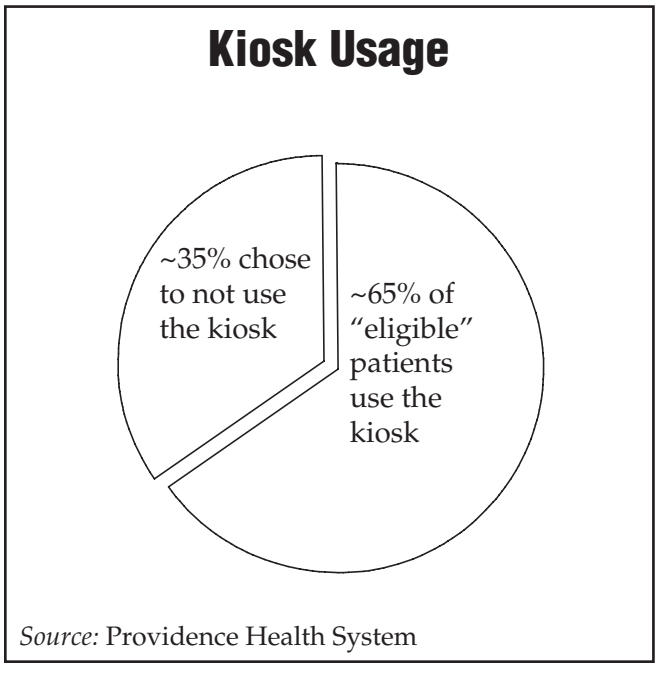
The kiosk prompts for date of birth verification and walks patients through a small number of screens, depending on their distinct registration needs.

The nine-page HIPAA form can be printed or is available from a rack on the side of the kiosk. Patients indicate that they have reviewed the form by using a stylus to sign onscreen, and may print a copy of the acknowledgment.

The conditions of service form also can be signed with the stylus. Both acknowledgements then feed automatically to the electronic medical record.

An access services representative, located nearby at her desk, can view what the patient at the kiosk is doing from her screen. She can see if the check-in is complete or if there are questions or problems. If at any point during kiosk check-in the patient is not able to complete all the steps, it instructs the person to step to the registration desk to complete check-in. If the check-in is completed as expected, the kiosk sends a message to the host information system that generates an order into that system so clinical staff know the patient has arrived and has checked in.

On the first days after the "go live" date, greeters were deployed to the kiosks to encourage usage and help patients through their first time. Little help was needed. Patients have embraced this technology easily. Coupons for the coffee carts were given to thank patients for trying it out.



The kiosks have received very favorable comments from patients, who say they want to use it for other services, not just the designated diagnostic imaging services now offered. Kiosks are in operation at three Providence Portland-based facilities for mammogram patients.

Next steps include the ability to take patient payments at the kiosk and to print maps from any location in the hospital for way finding. Plans for the next one to two years also include statewide rollout for all scheduled services.

Central access services

Another tool created to improve patient satisfaction and the revenue cycle is the Central Access Services (CAS) department. This department, comprised of 70 employees, was created to support pre-registration and verification of benefits for services for all facilities in the state.

Staff in CAS function as members of one of four teams: customer service/pre-registration, verification, maternity, or special teams. The special teams group handles verification for all same-day admissions, either directly or from the emergency department, and re-verification for patient type changes or extended lengths of stay.

Notification of these changes to CAS is accomplished through system-generated reports that print directly to CAS and the ability to queue accounts directly to CAS worklists by entering system notes.

This department has been able to succeed with innovative software programs that queue up patients from the scheduling systems and present them in an automated, pre-designated worklist sort format. This ensures that no accounts are missed and that all accounts present to the customer service team as soon after scheduling as possible.

CAS has a goal of pre-registering and verifying 97% of all scheduled services prior to date of service. In 2005, this team surpassed its goal, with 98% completions.

The high completion rates are largely attributable to the fact that these employees are dedicated to this task only. When these duties are assigned to staff on site in facilities, many times employees are pulled away to cover for absent team members who staff a front desk for walk-in patients. In that scenario, patient pre-registration

opportunities may be lost.

The additional goal of being two weeks out on pre-registration and verification is always a challenge but is most commonly the reality now that this team has matured. The 2% failure rate is related to patient unwillingness to call back or to pre-register over the phone.

The teams in CAS also can queue up printing of facesheets at any designated location either by a predetermined batch mode at designated times or on demand when required with updates noted. These teams also have access to real-time eligibility and batch eligibility exception reports on an ongoing and nightly basis to ensure clarity in account sponsorship.

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'Patients First' initiative has access component

Brochure to be part of admission packet

The voluntary posting by Massachusetts hospitals of their staffing plans — a first-in-the-nation initiative — has sparked "wonderful feedback" on what the effort has meant to patients and hospitals, says **Karen Nelson,** RN, senior vice president for clinical affairs with the Massachusetts Hospital Association (MHA).

After the staffing information first was posted in late January 2006, hits on the "Patients First" web site (www.patientsfirstma.org) went from an average of 2,300 a month to about 20,000 in less than three weeks, Nelson adds. "It has generated a lot of interest, both locally and nationally."

Patient access directors are expected to be a key part of the program, especially in the distribution of an accompanying brochure titled "It Takes a Team," she says.

"[The brochure] addresses the fact that whether planned or not, a hospital stay can be confusing," Nelson notes. "It makes the point that a variety of providers are involved in your care, and that [the hospital] wants you to know who they are and what they do.

"Ideally, we're hoping to distribute it as part of the admitting process," she says. "We're asking [patient access and admitting departments] to include it in the admissions packet or materials, and we certainly would like it to be on [nursing] units and at points of entry."

The brochure, which is available in English and Spanish, is accessible on the web site and has been provided in reproducible form to every Massachusetts hospital, Nelson says. "We've also distributed samples to the Massachusetts Medical Society and the American Association of Retired Persons."

Hospitals can place their own logos on the brochure, she says.

While the initial target audience is Massachusetts, Nelson adds, the brochure also would make sense for patients elsewhere. "The questions are applicable inside and outside the state. There are questions on quality and safety, and about what to expect when you go to the hospital."

Dialogue opened up

The posting of staffing plans was "certainly meant to be a patient pleaser" and has created a dialogue between providers and patients, Nelson notes. "As a bonus side effect, it has opened up dialogues between nurses and among leaders in different hospitals about identifying best practices and sharing information. So it's a concentric circle."

The staffing plans "are like a budget for the year for every single unit in the hospital," she says. "Supplemental information explains how care is delivered, and who else is on the team.

"It gives patients a real picture of how care is delivered. It helps them understand that care needs to be customized to them, and makes the point that care needs to be flexible and that hospitals want to ensure that they receive the right care, not always the same care."

There is information describing the different types of intensive care units, medical and surgical units, and how rehabilitation hospitals differ from acute care facilities, Nelson adds. "It answers some questions and also possibly provokes more questions."

The staffing plan posting and the brochure were put together under the larger umbrella of "Patients First," an initiative dating back to 2005 that began with MHA and the Massachusetts Organization of Nurse Executives, she says.

"The hospital association and the nursing executives got together and said, 'What can we do about some of our common concerns about quality and safety and staffing issues?'" Nelson says.

The idea of posting the staffing plans was vetted with hospitals and nursing organizations, she notes. "There was a variety of responses 'Should we do this? Are there any risks?' We felt it was important to be transparent about our quality and safety agenda and particularly what our staffing looks like. It took courage, but eventually every hospital agreed to participate.

"This is the culmination of a year-long effort, but it's just the beginning of where Massachusetts hospitals are going," adds Nelson. "We are continuing to build on our quality and safety agenda by implementing National Quality Forum [NQF] measures related to nursing care."

Massachusetts hospitals have agreed to participate in NQF measures such as patient falls, prevalence of pressure sores, and incidence of infection from central catheters, she says.

"We hope to learn lessons such as, 'How does one pilot these measures statewide in terms of standardization?' We will publicly report at least two measures." ■

FEMA to strengthen response capability

Real-time data to be provided

The Department of Homeland Security (DHS) has announced that it will establish a stronger set of communications capabilities to ensure timely and accurate awareness of conditions and events unfolding during a disaster, among other changes aimed at strengthening the Federal Emergency Management Agency's ability to respond.

These capabilities are to be achieved through interoperable equipment able to function despite loss of power, damage to infrastructure and severe weather, and enhanced communication functions to provide real-time information that can be used to inform decision making and prioritize resource requirements.

DHS says it also will develop a more sophisticated logistics management system to better track shipments of materials and equipment, manage inventories, and ensure effective distribution and delivery of needed supplies.

The new system will include a streamlined logistics supply chain to maximize readiness and ensure inventories and networks are in place to deliver supplies and assistance, while also replenishing stocks, in a reasonable amount of time.

Changes designed to enhance customer service and intake procedures, DHS says, will include:

- Upgrades to the FEMA web site and 1-800 call-in number to double existing capabilities by handling at least 200,000 disaster registrations per day;
- Advanced information technology and computer systems to more easily gather, search, and track case-specific information;
- Continued training on professionalism and customer service for DHS personnel; and
- The establishment of a highly trained unit of permanent employees, in addition to volunteers, to serve as a core disaster work force. ▼

Survey shows barriers to electronic health records

Hospital and health system finance executives view a lack of national information standards and available funding as the top barriers to adoption of electronic health records, according to a recent survey by the Healthcare Financial Management Association (HFMA).

Six in 10 finance executives surveyed were worried about the lack of consistent standards and code sets, and eight in 10 expect the government to facilitate the development of national standards.

COMING IN FUTURE MONTHS

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- An update on regulatory concerns
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Many respondents say they also expect the government to provide grant funding and other payment incentives for electronic health record development, and to accelerate investment in regional networks.

Hospital executives also say they want "clear guidelines from the federal government on how to provide computer support to physicians without violating the Stark/anti-kickback laws," HFMA said. ▼

Quality data accuracy examined by GAO

The Government Accountability Office (GAO) has released a report examining the processes the Centers for Medicare and Medicaid Services (CMS) uses to ensure that quality data submitted by hospitals for CMS' annual payment update program are accurate and complete.

The report also examines the accuracy and completeness of the data submitted for the first two quarters of the program.

Overall, the median accuracy score exceeded 90%, which was well above the 80% accuracy threshold set by CMS, the GAO said, and about 90% of the hospitals met or exceeded that threshold for both the first and second calendar quarters of 2004.

The agency said CMS did not assess the extent to which all hospitals submitted data on all eligible patients, and recommended CMS assess the level of incomplete data to determine the magnitude of underreporting, if any. ▼

CMS posts new FAQs on HIPAA standards

The Centers for Medicare and Medicaid Services (CMS) has posted answers to two new frequently asked questions (http://questions.cms.hhs.gov) about the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification standards.

The first question (ID# 6595) primarily has to do with the use of the proposed transaction standard for claims attachments, and whether health care providers can use the proposed standard ahead of a final rule. The answer is yes.

The second question (ID# 6594) addresses which business structures are considered "organizations" under the final rule for National Provider Identifiers. ■

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