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IN THIS ISSUE

OCTOBER 2006
VOL. 25, NO. 10 • (pages 109-120)

Care starts on arrival with centralized admissions area at Elmhurst Memorial

Assessment, initial testing done before patient goes to nursing unit

A centralized admissions area (CAA) at Elmhurst (IL) Memorial Healthcare handles much of the workups and assessments that unit nurses typically do, minimizing treatment delays and enhancing patient throughput.

Patients who go through the CAA arrive on the nursing unit having received a complete evaluation, with lab work and tests done and antibiotics and pain medication ordered, says **Matthew J. Lambert III,** MD, MBA, FACS, FACHE, senior vice president, clinical operations.

The CAA is one of several Elmhurst Memorial initiatives prompted by a hospital-wide operations improvement program that began several years ago, adds Lambert, who oversees the program along with the chief financial officer and director of process redesign.

"We spent about a year in the non-clinical areas and the last two-and-a-half years in clinical areas," he says. "We identified a lot of problems with interdepartmental communication. Every department was doing an excellent job, but they were not cognizant of, or sensitive to, the demands they were putting on other departments. They were optimizing their own particular enterprise."

As is true of many hospitals, Lambert says, "there were areas where patients that needed to be admitted to the hospital were sort of stuck."

More than 50% of admissions come through the emergency department, where patients are often hung up waiting for beds, he says. While Elmhurst Memorial is an older hospital with capacity constraints, Lambert notes, conversations with nurses indicated there was another reason for the long wait.

"We found out that there was a reluctance to accept new admissions related to the amount of work involved," he says, "so there was a lack of cooperation [from nurses], a passive-aggressive attitude."

As the operations improvement team investigated further, Lambert continues, they realized that just streamlining the ED process would not solve the problem. "Patients would just wait longer — getting to the

floor faster did not mean getting care faster."

"We also found that admissions and discharges peaked at the same time — between noon and 3 p.m. — as physicians come in later in the morning to discharge patients," he adds. "We realized we had to fix everything, not just one thing."

The CAA originally was designed to address direct admissions, Lambert says. "Patients directly admitted from the physician's office or by phone would wind up on the unit without orders because the physician hadn't sent them. They would be languishing up there and [hospital staff] couldn't get hold of the physician."

Even if the orders came, nurses would be busy with something else, he says, "so the patient would be in bed, but nothing was happening. They might not get a meal, or they might not get pain medication for several hours."

To accommodate the five-bed CAA, Lambert says, the hospital designated a space formerly used by physicians to see patients for exams or minor procedures on an outpatient basis.

"We staffed it with a couple of RNs and a couple of technicians," he notes. "We insist that orders come with the patient, and if they don't come, [an access nurse] calls the physician's office and asks [staff] to fax them over."

Patients go through the registration process, which is done at bedside, and the initial orders are completed in the CAA, Lambert says. "We try to get as much done as possible before the patient goes up to the unit."

There are five private treatment rooms in the CAA, he notes, where family members can sit with patients while the initial orders are completed. Patients typically spend about three hours in the CAA, Lambert adds, and once the X-rays, blood work, or other procedures are finished, they go to the nursing unit.

"For the nurses on the floor, [the CAA] has eliminated what, with the documentation that is required, could be a two-hour process," he says.

The CAA's hours of operation initially coincided with physician office hours, but have now been expanded to seven days a week, Lambert says, and the CAA is now picking up a lot of overflow from the ED. "About half the patients [the CAA is] seeing are direct admits, and half are from the ED."

The maximum number of patients seen in the CAA on a given day is in the mid-20s, he adds, which is about half the daily admissions.

The CAA has been a key factor in improving the flow into the hospital, Lambert says. "In the past, it was not unusual for a patient to wait several hours for antibiotics. Now that wait is down to less than an hour."

Two years ago, patients admitted from the ED spent an average of 348 minutes, or 5.8 hours, waiting there before admission, he says. As of June, that wait had been reduced to 234 minutes, or 3.9 hours.

Patient reaction to the CAA has been mixed, Lambert notes. "From those coming from the physician's office, it's positive, but ED patients have a little trouble understanding why they are being moved from one area to another. Some patients

Hospital Access Management™ (ISSN 1079-0365) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals 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, (ahc.customerservice@thomson.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. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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assume once they leave the ED they're going to the floor, and that doesn't always happen."

Some patient education is required, he says. "We explain to them that before they go to the room we're going to finish the rest of their testing and procedures, so they won't have to come down again [right away]."

Getting a bed was 'like pulling teeth'

Historically, it was "like pulling teeth to get a reservation" when a registrar called to find a bed for a patient, with unit nurses always saying beds were not ready, notes **Cindi Ruffner,** manager, registration and scheduling.

Now access nurses — who have been in place about five years, three years before the CAA was established — take reservations from physicians and arrange for bed placement, among other functions, Ruffner says.

Their role, according to **Sue Prestipino,** RN, one of two access nurses, was created from a quality and financial perspective, to make sure patients are placed appropriately according to clinical needs.

The nurses, who report to the quality resource management department, look at whether the patient is under the correct admission status and at the right hospital according to payer guidelines, she says. The main focus, however, is on quality, Prestipino adds. "We were trying to organize the process so that once people arrive, we can expedite them through the system in a timely manner."

The access process

From the access nurse's perspective, she says, the process works as follows: "The physician will call with an admission request. We screen for medical necessity and appropriate placement, and set up an appointment for the patient to come over. We are able to discuss the clinical course, which helps us place them."

Orders are either given verbally by the physician, faxed over, or arrive with the patient, she adds.

For the past year, Prestipino notes, access nurses have handled bed control for the entire hospital, so they take care of that piece as well. "It's a good fit," she says. "Before that, a clerical staff did bed control and [patients] just came when the physician sent them."

The access nurses work with a computerized bed board, Prestipino adds. "We know when there is a discharge, so we know when there is room for them."

"We make the reservation for admission, secure the orders, and when the patient arrives, one of the access nurses meets them in the lobby," she continues.

That step is both a customer service gesture and an opportunity to assess whether or not the patient is able to go through the regular admission process or needs additional help, Prestipino says. "People like to know they're expected."

Then the access nurse takes the patient to the CAA, she adds, noting that all the areas involved — admissions, the access nurse office, and the CAA — are close to each other and to the main entrance of the hospital.

At that point, the CAA staff takes over, doing the assessment, computer work, and any orders that need to be done immediately, Prestipino says. "The goal is to get them in and out in two hours," she notes. "Patients in the CAA have priority in our testing areas."

Access nurses perform a similar function with patients who are being admitted from the ED — reviewing the case and working to find the most appropriate placement, Prestipino says.

If there is an opening in the CAA, she explains, the patient is taken there to complete the process, which is not as lengthy because of the testing that has already been done in the ED. If the CAA is full, Prestipino adds, the patient will go directly to the nursing unit.

"The idea is to maintain a smooth patient flow, and [to avoid] having a lull in care," she says. "The patient is always being treated, always being worked on."

In addition to the CAA being "a big satisfier for nursing staff," it has helped promote good relations with physicians, Prestipino says. "There is also more personal contact with patients, who are reassured that when they come in, somebody knows who they are, why they're there, and we guarantee their safety."

Elmhurst Memorial runs a very high census, as do most of its neighboring hospitals, she notes. One of the indicators of the organization's success with operations improvement, Prestipino suggests, is that the facility has never had to go on hospital-wide bypass. "We feel we're able to manage patient flow because of these processes."

[Editor's note: Matthew Lambert can be reached at Mlamber@emhc.org.] ■

'Ideal Patient Day' gives heads-up on care

Schedule serves patient, not just staff

When Elmhurst Memorial Healthcare looked at improving patient throughput, one of the issues that surfaced had to do with housekeeping, which historically had deployed its work force in a way that did not serve the facility, says **Matthew J. Lambert, III,** MD, MBA, FACS, FACHE, senior vice president, clinical operations. "We found that when we needed the most [housekeeping personnel], the fewest were there."

That problem, among others, was remedied with something called the "Ideal Patient Day."

"When a patient is discharged that is put in the computer, housekeeping is notified, and [staff] have a timeframe in which they have to respond," he explains. "Rooms don't sit around empty."

However, the concept extends far beyond room turnaround, Lambert says.

"One of the things any physician or nurse will tell you is that in many hospitals, patients are basically diagnosed and treated at the convenience of the particular department that is doing whatever it's doing."

Patients can be resting, having lunch or seeing visitors, he continues, and someone will call and say, "We want to take Mrs. Jones to X-ray."

With the advent of the Ideal Patient Day, all patient activities must be scheduled in the computer, Lambert says.

"If physical therapy wants to see the patient, or radiology, they have to schedule a time, so [everyone involved] knows exactly what's going on with that patient for that day — within reason," he says. "Obviously there could be an emergency that would change that."

Know where your patients are

The new process has been very helpful, Lambert says. "Patients are getting to tests on time, tests are known about in advance. [Staff] no longer come up to the unit and say, 'Where is Mrs. Jones?' and hear, 'I don't know. She must be

Provide entire staff with leadership opportunities

Leadership program open to all

It's the philosophy at Elmhurst (IL) Memorial Healthcare to offer leadership opportunities to employees at all levels and in all areas of the organization — not just the "top 15 or 20 people" in the traditional management hierarchy, says **Matthew J. Lambert, III,** MD, MBA, FACS, FACHE, senior vice president, clinical operations.

"There [typically] is a lot of attention paid to the formal leadership structure and it was our feeling that we needed to broaden the opportunity for other people to be exposed to leadership roles and experiences," Lambert adds.

With that in mind, he says, Elmhurst Memorial began a "homegrown" program for directors and managers in which employees are exposed not only to topics of leadership, but to financial information and skills such as how to run a meeting.

"The CEO and I do a half-day program on leadership," Lambert notes. "We have [participants] read 'Leadership Is an Art,' by Max Depree, and the CEO talks about his years of experience in health care."

There is a leadership institute that runs throughout the year, he says, which consists of the following topics:

- The challenge of leadership
- Mastering meeting and project management
- Leading for regulatory compliance and ethical behavior
- Effective business writing
- Financial skills for leaders
- Presentation skills
- Leveraging the power of technology
- Tips to enhance computer and telephone skills

There is also an effort to populate the organization's major committees with employees from throughout the organization, Lambert says. "We are building a new hospital and we have a number of employees, managers, directors [involved]. A lot are doing service line analysis.

"We have tried not to do it as a top-down process," he adds. "We have 3,000 employees, and these are very talented people. We're looking for ideas from anybody, and we recognize that it's not just the people with titles who have the ideas." ■

in X-ray.'"

Computerized screens much like those at airports, but not as large, show where the patient is and what is scheduled, he notes.

The three people who oversee the operations improvement program — Lambert, the chief financial officer, and the director of process redesign — spent a lot of time brainstorming solutions aimed at improving patient care, he says.

The Ideal Patient Day, for example, was an outgrowth of looking at how other industries do things, Lambert adds. "One of the things that piqued my interest was that if you have a package sent by Federal Express, you can get on the Internet and follow that package.

"I started thinking about that and said, 'FedEx treats packages more like people, and we treat our people more like packages. Why don't we take a look and try to figure out how to do that kind of tracking?'"

Using an airport metaphor, he says, it's like having someone in the control tower — the nursing unit — who knows what's going on.

Despite the obvious benefits, implementing the Ideal Patient Day has not been easy, Lambert says. "It has created a lot of controversy in our organization.

"What it has done is it has taken away the autonomy of the department and the individual," he points out. "Physical therapy has been very resistant to scheduling appointments. [Physical therapists] like to show up when they want to show up. The clinical nutritionist is also a little unhappy."

The goal of the initiative is to put control back with the patient, Lambert says, and to get across the message to hospital staff that "it isn't just about you and your timeframe. We have to make sure the patient is not pulled away in the middle of lunch."

While people understand this conceptually, he adds, it's difficult for them to accept that they can't do what they want, when they want.

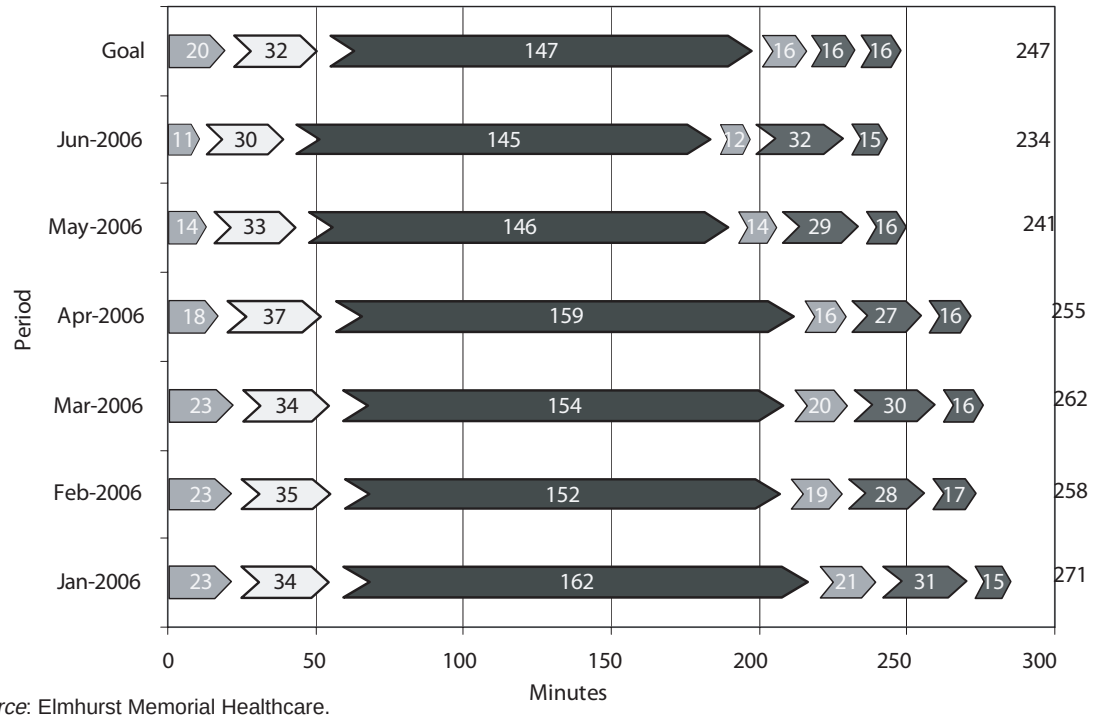
"When hospitals are facing this issue of capacity, admissions, discharges, getting people in and out, there are no quick fixes," Lambert emphasizes. "You have to go in and look at all departments."

And, he adds, "you have to be ready to get in deeply, measure everything. We break down the ED experience from the time the patient walks in the door to [discharge], with about eight different points and established goals for each of them. We measure not just the overall experience, but each individual segment." **(See illustration below.)**

The information that is tracked and presented on a regular basis includes the following:

- arrival to triage time

ED-Admitted Patients' Average Length of Stay and Flow



Source: Elmhurst Memorial Healthcare.

- triage to room time
- room to MD assessment time
- time from when patient is placed in room until nurse sees the patient
- admission order to bed assignment time
- bed assignment to transportation order time
- transportation order to depart from ED time

"One of our major stumbling blocks was the transportation department — delays in getting a transporter," he says. "Now they all have time limits and expectations, and we deploy them to certain areas at certain times of the day."

Improving patient throughput and access to care requires an organizational understanding that there are no independent departments, Lambert points out. "If each department is seeing to maximize its own success, it's at the expense of others." ■

Need throughput solution? Try discharge planning

Remember the basics, veteran CM says

As hospitals struggle to improve patient throughput by streamlining their emergency departments and installing bed management software, they often discount one of the most basic tools at their disposal, says **Jackie Birmingham**, RN, MS, CMAC, a veteran case manager and discharge planner, who is now vice president, professional services for Curaspan Inc.

As health care providers focus on utilization review (UR) and cancel elective surgeries in response to the capacity crisis, they overlook the power of proactive and comprehensive discharge planning, adds Birmingham.

"Whenever I hear [providers] talking about patient throughput, they sort of [add] 'and, oh, discharge planning,'" she says. "When I listen to patient throughput scenarios, there is talk about bed management tools and ED fast track, and what's happening is that the case manager is spending a lot of time doing UR and not enough time counseling on the patient's readiness for discharge."

Birmingham says she recently came across a situation in which a patient was in the hospital for 10 days, but not until the morning of discharge did staff begin to go over diet and medication issues. At that point, she adds, the family learned for the first time that the patient — who was being treated by several specialists, including a cardiologist and a pulmonologist — had developed prednisone-induced diabetes during the stay and was on insulin.

"I think that the case manager was very involved with getting approval for the nursing home stay and tracking continued stay [criteria]," Birmingham says, "but when it came to the simple discharge plan, that kind of got shunted off."

If UR staff are thinking that a patient is getting close to the end of what will be considered an appropriate hospital stay, she advises, the discharge planner should be actively involved in the process.

"This [concept] is so old — discharge planning rules were proposed in 1986 and passed in 1988," Birmingham says. "But now the admitting staff are looking at what beds are available and predicting how long the patient should be there so they can book the next surgery, and the case manager is looking at the clinical processes that justify the continued stay.

"When it comes time to discharge the patient," she adds, "it seems to be a surprise."

There is a mindset among many patients admitted to the hospital, Birmingham suggests, that they are not going to leave until they are totally independent.

"They don't understand that acute care is a very short part of their episode of care, so they want to stay longer," she says. "It's not all patients, but it's the elderly person with a cardiac condition, who has a child [providing care] who might also be elderly with a cardiac condition.

"The fact that patients come into the hospital and are not the way they were before and probably never will be is kind of a shock to the family," Birmingham adds. "The family still pictures the hospital as where you go and get better, but it is where you go and get stabilized. [The patient] is like, 'I'm not well enough to go home, but I don't want to go to a nursing home.'"

Meanwhile, she says, the family is not brought up to speed on short-term nursing homes or home health or adult day care.

Discharge planning and patient throughput

"In the tweaking of patient throughput," Birmingham continues, "they're not putting enough emphasis on discharge planning. It was intended to move patients. Some people look at discharge

planning as writing a plan and being done with it."

She recalls talking to a group of engineers who posed the question, "If discharge planning starts on admission, why does it take so long to discharge a patient?"

What is lost sight of, Birmingham says, is that "discharge planning" is an active term. "It's *planning*, not a *plan.* It's assessing a patient: If you're going home, well, what do you need to go home? Do you need to see a physician? Do you need equipment? Do you need medications? Do you need to be taught how to test blood sugar?"

Without proper attention to those questions and others, she says, within a short time "the family is clamoring for information, calling the physician back — and the readmission rate from home health care is almost 40%.

"Patients going to a nursing home get a lot more scrutiny than those going to home health care," Birmingham adds. "I'm putting the blame on discharge planners. They may think home care is fairly routine, but it's really risky [for patients] going to an environment where there is not 24-hour care."

A discharge plan is more like a video than a snapshot, she notes. "It's a moving reel, and then you take a snapshot at the end.

"It can be done along with other tasks, and fits quite nicely with case management, utilization review, and clinical pathways," Birmingham says. "Capacity management is so important now that a little more emphasis is needed on how you do discharge planning."

(Editor's note: Jackie Birmingham can be reached at jackiebirmingham@sbcglobal.net.) ■

Maryland facility begins discharge by appointment

Plan 'truly' begins at admission

This month, St. Joseph's Medical Center in Towson, MD, begins discharging patients by appointment, in the latest phase of a three-year effort toward capacity maximization, says **Jackie Connor,** RN, MS, CCS, director of case management.

When Connor was hired in April 2005, she was asked to take over the part of the project that included improving the discharge process, "the back end of patient flow," she adds. "Other teams were working on the emergency department [ED], the front end.

"We had an issue with 'boarders' in the ED and as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80% of the problem should be fixed."

Connor says her sense of the situation, however, was that a more comprehensive solution was needed. "We put together a multidisciplinary team last June, started working on the problem and, as we moved forward, put together subgroups as issues arose."

When the discharge task force was established in June 2005, one of the main goals was to increase the percentage of patients discharged by noon, Connor adds. But even with that specific intent, several months of data collecting revealed little change.

"What we found was that it was causing what we called 'bolus' discharges," she says. "It was a rapid, concentrated effort, a massive amount of patients, trying to get it all to happen before noon.

"Later in the day we would have 'bolus' admissions as the ED and the catheterization lab would empty out," Connor adds, "so there was not an even workload throughout the day."

That's when the decision was made to move to discharge by appointment, she says. "What we're attempting to do — and I haven't seen this in any of the literature on the subject — is to try to schedule discharge for *all* patients, not just surgical patients."

The idea has been piloted on the surgical unit with some success, and then with interventional cardiology patients, and is now being expanded to all patients, Connor notes. One group that will not be included is the maternal/child patient population, she adds, because there are no throughput issues there.

The process works as follows, Connor explains.

1. Planning begins on admission for the anticipated discharge.

"I know everybody says they do that, but we truly are going to begin — meaning we will assess the patient, discuss the plan, and then set the anticipated date."

2. Nursing, case management, and physicians work daily on evaluating the plan and the antic-

ipated date.

3. Ancillary departments will be notified of the anticipated discharge date and time and their turnaround of tests and procedures, and their goal is to meet the deadline — to prioritize based on the date given.

4. The patient is informed all along the way of what the plan is.

"We're trying to plan from day one to get everybody moving in the same direction," Connor adds.

The team will monitor:

- **The percentage of patients who have a discharge appointment.**
- **The percentage of patients who have an appointment who are discharged within 30 minutes of the appointment.**
- **The percentage of patients who are identified as potential discharges at least 22 hours prior to the actual discharge.**

(Editor's note: Jackie Connor can be reached at jackieconnor@chi-east.org. Look for a follow-up on the 'discharge by appointment' initiative in a future issue of Hospital Access Management.*)* ■

On-line referral system aids in Katrina aftermath

Relocations impacted process

In the aftermath of Hurricane Katrina, which hit the Gulf Coast in August 2005, the already challenging task of arranging discharges and communicating with post-acute providers became even more daunting, says **Louise Bourgeois,** RN, CPUR, director of hospital patient financial services at Ochsner Medical Center in New Orleans.

An on-line reservations and booking system called eDischarge that was in place just a few months before Katrina hit helped streamline that process and "made life easier," she adds.

"We've had such a different type of environment since the hurricane, with very limited [numbers of] post-acute providers," says Bourgeois, who oversees admitting, emergency department registration, and case management. "When we came back following the hurricane, we were trying to find out who was open and who was not open."

Both the hospital and the post-acute providers who were open faced staffing problems, she adds.

Discharge and placement efforts were complicated in the weeks and months following the hurricane, Bourgeois explains, because of relocation issues affecting patients and families.

"Some patients are here [in the hospital] for care, but their families are up north in Louisiana, or out of state," she says. "When those patients are discharged, they want to go where the family is."

Before eDischarge, staff had to go to the Yellow Pages in the telephone book, look up the area being targeted, and start calling providers, Bourgeois says. "Now we go to eDischarge and enter the zip code."

Her staff use the tool, a product of Needham, MA-based Curaspan Inc., to interface with post-acute providers, she adds. "They put in patient needs, area code, and zip code of the patient. We can send the request to multiple providers at one time."

If a provider in the area can accommodate the patient, staff there respond via eDischarge, Bourgeois says. One of the big advantages of eDischarge, she points out, is that the request can be sent to multiple providers at one time.

When a social worker comments that she can just as easily pick up the phone and call a provider when she has a patient who needs home health care, Bourgeois says, she reminds her that what gets complicated is what comes after that quick call.

"The next thing is, 'Well, fax over the information,' and you do that, and then you wait, and it may be two hours and then the answer is that they won't take the patient," she notes. "And you have to do it one [request] at a time."

With the on-line system, Bourgeois adds, staff can hit a button and resend the complete patient file electronically as needed. When there is a response from a provider, it is tied to the social worker or case manager's pager, she says, so they don't have to sit by the computer waiting.

Help with documentation

The eDischarge system also adds efficiency when it comes to documentation, Bourgeois adds. "Our other concern is, 'How do you document that you've given the patient a choice, that you're really evaluating the post-acute providers, and their response to the patient, and

that you are giving equal opportunity to providers?"

Now, if a post-acute provider complains about not getting enough referrals, she says, Ochsner staff can pull up the information on eDischarge and show that in actuality that facility is receiving about the same number as any other provider.

When this kind of documentation had to be done manually, staff were always behind because it was not a priority, she adds. "They needed to do their work first. They were documenting their progress notes, but we often had to pay someone extra [to do the additional documentation]."

While the system is in use throughout her department, Bourgeois notes, "we still have a little ways to go with it" on a facility-wide basis.

Efforts are under way to extend eDischarge to social workers who report directly to the transplant and oncology departments, and to ED case management staff, she says. "We really would like to track all of our post-acute placements."

(Editor's note: Louise Bourgeois can be reached at Lobourgeois@ochsner.org. More information on eDischarge is available at www.curaspan.com.) ■

MD-Link gives access to referring physicians

UAMS records available on-line

Physicians from throughout the state — and country — who make referrals to the University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock can check their patients' records on-line thanks to a recently instituted program called MD-Link, says **Melanie Meyer,** director, physician relations, for the College of Medicine at UAMS.

The system is fast, secure, and HIPAA-compliant, Meyer adds, as well as being extremely user-friendly.

The UAMS idea originated at the annual meeting of the American Association of Physician Liaisons (AAPL), she says, where representatives from Dartmouth, the University of Ohio, and the University of Washington shared information on their efforts to provide referring physicians with Internet access to patient records.

"University hospitals are notoriously bad at communicating with referring physicians about their patients," Meyer notes, "and our campus has a long history of being communication-challenged."

The various AAPL members shared their models, and UAMS staff analyzed what others were doing in the field, she says. "Everyone's program is a little different."

The physician relations staff then began meeting with cross-campus groups at UAMS, including legal counsel, outpatient clinic managers, and representatives from information technology, admissions and registration, and medical records, Meyer adds.

The planning phase encompassed about two years, she says, noting that the sessions with the UAMS staff that oversee HIPAA compliance were some of the most complex and time-consuming.

"We had a year of just meeting about forms," Meyer says. "Since these kinds of programs are so new, [HIPAA staff] didn't have anything they could reference. We had to word things so there was no ambiguity. They were very diligent."

Many of the HIPAA concerns involved the process of obtaining patient authorization during registration, she says. "There are many checks and balances within the system to make sure patient privacy is protected."

The process works as follows:

• Patients fill out a form, writing in the name of the physician, either authorizing or denying their referring or primary care physician access to their medical record.

• Registration staff enter the information into the hospital mainframe computer and turn on authorization for the PCP or referring physician. They pick the physician's name from a menu and hit "yes," indicating the form has been completed.

• The PCP or referring physician has to review the UAMS confidentiality policy, and agree to be governed by the same laws and bound by the same agreement as are UAMS faculty.

• After the physician signs a confidentiality/authorization form, the UAMS IT staff mail him or her a password and log-on information.

• The physician goes to the UAMS web site and clicks on the MD-Link logo, then types in

(Continued on p. 119)

Patient label

Authorization to Allow Electronic Access to My UAMS Medical Record Through MD-Link System

What is the "MD-Link System?" An electronic system operated by UAMS that will allow your physicians who are not employed by UAMS, and appropriate members of their staff, to view and access your UAMS electronic medical record (if they choose to sign up for MD-Link access). **Why?** This electronic access allows your non-UAMS physicians to have a more timely and efficient method of accessing your UAMS health information for the purpose of providing your continued medical treatment.

Primary Care Physician *(The doctor you see for regular checkups)*	**Referring Physician** *(The doctor who sent you here or who needs your records from UAMS after your discharge)*	**Additional Physician** *(The doctor who needs your records from UAMS after your discharge)*
Name (print)	Name (print)	Name (print)
City State	City State	City State

Authorization and Purpose: I authorize and give permission for the physicians named above, and their staff as deemed appropriate by these physicians, to view/access my medical records stored electronically at UAMS for the purpose of my continued medical treatment, payment for my treatment, or limited health care operation uses permitted by the federal Privacy Rule. **I understand that I am not required to sign this Authorization,** and my treatment or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Health Information Accessed: I understand that this Authorization is for read-only access to my medical records maintained electronically by UAMS, which may include my medical records from other physicians, hospitals, and clinics outside of UAMS, and may include references to alcohol or other chemical dependencies, psychiatric conditions, sexually transmitted diseases, and HIV information, if any of these situations apply to me.

Expiration/Withdrawal of Authorization: If I change my PCP or want to terminate my referring physician's MD-Link access or if I sign this Authorization, I may withdraw it at any time by informing UAMS in writing to Physician Relations, 4301 W. Markham, #727, Little Rock, Ark. 72205. Any MD-Link access to my information previously provided by UAMS in reliance upon my signing of this Authorization will not be affected by my withdrawal at a later time. **I understand that it is my responsibility to inform UAMS so that these physicians and their staff will no longer have electronic access through MD-Link.** This Authorization will expire when my physicians named above are no longer my treating/referring physicians, and I have notified UAMS that they should no longer have MD-Link access.

Patient Signature or Patient's Legal Representative _____ Relationship to patient _____ Date _____

If Legal Representative signs, state relationship to patient (parent of minor, court-appointed guardian, healthcare power of attorney) (documentation required)

PLEASE NOTE that any of your physicians can still receive your medical information/records for purposes of your treatment, or other lawful purposes, by receiving such information by phone, mail, fax, or other means of delivery.

For more information, visit www.uams.edu

Denial of Physician Access - Complete this section only if you DO NOT want electronic access provided

☐ I **do not** want my PCP and/or Referring Physician listed below to have electronic access to my UAMS medical records through MD-Link.

Primary Care Physician _____ Referring Physician _____

Patient Signature or Patient's Legal Representative _____ Relationship to patient _____ Date _____

If Legal Representative signs, state relationship to patient (parent of minor, court-appointed guardian, healthcare power of attorney) (documentation required)

Printed Name of Employee processing request _____ Date _____

Source: University of Arkansas for Medical Sciences.

the user name.

• At the next screen, the physician types in the patient's name, which takes him or her into WebChart, a homegrown system used by internal UAMS physicians and interfaces with all of the components of the medical records.

• The physician can view discharge summaries, op reports, laboratory and pathology reports, radiology results, electrocardiograms, and outpatient notes, among other patient information.

Before MD-Link, she says, communication was "hit or miss" between referring physicians and UAMS physicians. "Some of our physicians do a really good job of communicating and that's what they teach their departments. But in academic medicine everyone has their own fiefdoms. Not all physicians place the same emphasis and have the same system in place.

"There are physicians who, if the patient sneezes, they dictate," Meyer continues. "There are others who say, 'I'm not writing letters.' Academic physicians struggle to understand [the importance] of communication. They haven't thought that you have to care about the people who are referring you the patients."

Registration staff play a crucial role in the process, as they capture the data regarding PCP and referring physicians, she points out. "That information is critical on any hospital system. It lets physicians know who they need to follow up with, and is also used for billing and appointment scheduling."

Referring information also has a marketing component, Meyer adds. "It lets you know who you're doing business with, probably the most important customer you have."

Some physicians 'dragging their heels'

UAMS began bringing up the MD-Link system in January, she says. After three months of getting patient authorizations on file, she adds, brochures were sent out to the all the referring physicians, both in and out of state, who had sent patients to UAMS within the previous two years.

"Arkansas is fairly rural, so many physicians around the state are still dragging their heels about electronic medical records," Meyer explains. "Many of them don't have computers."

The most interest in MD-Link has been shown by out-of-state physicians who refer patients to the UAMS-based Myeloma Institute for Research and Therapy, she says.

After six months of marketing, about 90 physicians had been enrolled, adds Meyer, who says she believes those numbers will increase "as our physicians are dragged into the 21st century."

Within five years, all physicians are supposed to have transitioned to electronic medical records, she says. "As we make that transition, this program will grow, and we will be ahead of the curve.

"People who use MD-Link think it's wonderful," Meyer adds. "They've been appreciative for the ease with which they are able to access records."

The intent for the future, Meyer says, is that MD-Link will evolve into providing a function whereby an automatic message will be sent to a referring physician when a step in the patient's care takes place.

"It will let the referring physician know that his or her patient has been seen at UAMS and that the record is available for review," she adds. "An e-link will go out."

While it would be convenient for physicians to actually receive the record by e-mail, Meyer notes, "from a HIPAA standpoint, it is so hard to guarantee security."

One of the next steps in this arena is for UAMS patients to have access to their medical records, she says. "We're just now getting the ball rolling on that."

(Editor's note: The Physician Relations office at the University of Arkansas for Medical Sciences is interested in hearing suggestions from other hospitals that have experience with systems like MD-Link and would be happy to share forms or policies and procedures it has developed. Melanie Meyer can be reached at meyermelaniem@uams.edu.) ■

COMING IN FUTURE MONTHS

- Access lessons learned during Katrina
- Disaster victim locator
- 'Turnstile ED' program
- Inpatient preservice collection
- Access regulatory update

NEWS BRIEFS

Gulf area emergency care still not recovered

The emergency care system in Gulf Coast areas devastated by Hurricanes Katrina and Rita still has not recovered and progress is slow, the American College of Emergency Physicians (ACEP) reports.

In an ACEP survey of 59 physicians in the affected areas, 93% said bed capacity was at least 25% below what was needed to care for patients, while 96% said their emergency department (ED) was experiencing staffing shortages in areas such as nursing.

Eighty-seven percent reported increases in the number of uninsured patients seeking emergency care. One-third of respondents said some parts of the medical care system had experienced significant progress, while one-third said they would consider leaving to practice in another state if the post-hurricane recovery was not sufficiently improved in another year. ▼

Katrina survivors still suffer limited access to care

Survivors of Hurricane Katrina continued to suffer emotional and mental trauma and limited access to care and medications for months after the storm, largely because of a sharp reduction in charity care and lack of insurance, according to a recent report.

The Kaiser Family Foundation interviewed low-income victims of the storm in New Orleans, Baton Rouge and Houston five to six months after the hurricane struck, and found that many went without or experienced gaps in care, had difficulty accessing mental health services, lacked transportation to needed health care, or could not afford both health care and other basic needs.

The report "underscores the need for health care planning to be an integral part of the overall homeland security infrastructure," said Ernie Schmid, director of policy analysis for the Texas Hospital Association. "Provisions must be made for both acute and primary health care needs, and the response must involve a broad range of health care providers across traditional jurisdictional lines." ■

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