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Patient flow team follows ED admits from first encounter to discharge

Access program provides 'a way for patients to connect the dots'

At Forsyth Medical Center in Winston-Salem, NC, patient flow representatives begin working to positively impact a patient's experience the moment he or she enters the emergency department (ED), says **Kirsten Royster**, MPA, director of patient access.

What takes the initiative to another level altogether, she explains, is that those employees continue to follow patients not only until they are discharged or admitted, but through the entire hospital stay for those who become inpatients.

Forsyth began the program in December 2005, Royster says, as a way to facilitate throughput and provide better care and customer service in the ED setting.

"It's challenging when patients are asked [for a customer satisfaction survey], 'How would you rate your admitting experience?' That's a pretty broad question. From the patient's perspective, it [covers] the moment you come in the door of the ED until you're actually in an inpatient bed," she points out.

"There are so many [factors] that have an impact on that experience," Royster adds. "We thought this would be a way for patients to connect the dots, so they weren't seeing two distinct areas of care."

To make the program a success, she says, the hospital needed "someone who was truly that person's advocate — not a nurse, not a tech in the ED, but truly outside that — who could focus on what to do to get from the ED to the nursing floor or discharged home."

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards regarding ED throughput and overcrowding were another impetus for the program, Royster says. "We thought this would be another way — in addition to throughput committees and tracking documents — of addressing that."

Three full-time equivalents (FTEs) — converted positions from the hospital's environmental services department — were designated for the program, she says. They were filled by a patient flow coordinator

who reports to her, one full-time patient flow representative, and two part-time reps, Royster adds.

"We were trying to spread the hours so we'd have people there when the ED is busy, so the goal is 10 a.m. to 1 a.m., or even later," she explains.

The effort received a boost in June, Royster says, when the decision was made to incorporate existing ED guest services positions into the program and the number of employees went from four to 11. Patient flow representatives now perform the guest services role — check-in of patients before triage — in addition to working with patients in the treatment area, she adds.

"It's a nice collaboration," Royster notes. "The person in the lobby knows how many people are there, walking in the door and waiting to be seen, and can communicate that to their teammates in the back."

A patient flow representative may be in the lobby performing the guest relations piece for three hours, and then go to the back for the remainder of a shift, she says. "They have a fuller knowledge of the entire operation, and it has allowed us to have a lot more collaboration among all the areas of the ED."

In addition to providing more comprehensive service to patients, that step has been a real staff satisfier, notes **Andrew Cox,** the patient flow coordinator.

"The people who used to just work in the lobby love the fact that they are now rotating through," he says. "When I was up front [in guest services], I didn't have anybody to ask, 'Can you go to bed 12 and see if that patient can have the family come back?'"

Now, Cox adds, the person up front can make that call to a teammate in the back, who, for example, might respond, "No, they're still doing the assessment on that patient, but I'll let [the family] know when they can come back."

That teammate, he continues, might then come out in the lobby, introduce himself to family members as a patient flow representative, and say, "As soon as the patient's assessment is finished, I'll be glad to escort you back."

In the past, if the guest services representative checked on someone in the back, he or she risked missing other patients or family members who arrived in the interim, Cox points out.

Nursing staff like the new process, as well, he says, because during trauma and code cases they can depend on the patient flow representative to look out for arriving family members and inform clinicians when they arrive. Before, Cox adds, a nurse might have had to take the time to make those connections.

'Four-hour mark' is trigger

The Forsyth Medical Center ED is divided into a "major" area with critical cases, including those transported by emergency medical services; a "minor" area with less urgent cases; and a fast-track area, Royster explains. At present, she says, the patient flow staff work with any patient in the major or minor area who has been in the ED more than four hours.

"By the four-hour mark, there is usually the

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Editorial Questions

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need for somebody to communicate," Royster says. "If there are not as many [patients], we do it sooner, and any trauma or 'code' [case] is outside the four-hour [rule]. We work with all of those.

"The intent behind [providing the service] is really to look at throughput, and the biggest issues are with the major or minor cases," she adds. "They are either about delays getting home or delays getting to the nursing floor."

From November through April, during the hospital's high census period, patient flow staff work with any patient who, after a determination to admit has been made, has to wait in the hallway for a bed because of overcrowding, Royster notes. "If they're not in a bed, they're already less satisfied. We help them understand how busy we are, why they're in the hallway, and what we're doing to get them where they need to be."

There are always two, and typically three, patient flow employees on duty, she says, and if there are three, one is in front and two are in the back of the ED.

Job processes for patient flow representative

Following is a summary of the major job processes of the patient flow representative job at Forsyth Medical Center in Winston-Salem, NC. Other duties not mentioned below may be performed and specific activities may change from time to time.

Patient flow

- Facilitate the flow of patients arriving in the emergency department, particularly those patients who require an inpatient admission.
- Seek and accept daily feedback and direction from the patient flow coordinator.
- Coordinate key decision makers in promptly addressing patient throughput issues.
- Collaborate with nursing supervisors and clinical staff to facilitate patient movement.
- Take proactive steps to be the patient's advocate so that he or she moves through the process quickly.
- Communicate with bed control and environmental services staff related to bed readiness.
- Meet with patients in the emergency department awaiting treatment / procedures to:
    - seek clarification to respond to patients' and families' questions;
    - educate patients and families on the emergency department and admitting processes;
    - communicate procedure status to patients/families if requested. Provide timely updates to patient/family as information changes;
    - receive feedback: Probe for concerns, needs, and impressions of service;
    - inform families of hospital amenities;
    - provide food / beverages as allowed per physician orders.

Guest Services (Emergency Department Lobby)

- Greet arriving patients and guests in the lobby.
- Input data into the tracking system.
- Answer questions of patients or guests and advise of pending wait times.
- Educate guests on ED protocol.
- Answer the incoming telephone calls following the Novant Health standards.
- Serve as a resource for families and guests in locating patients who are being treated and give directions to locations within the hospital.

Customer service / communication

- Facilitate excellent customer service to ED patients.
- Serve as a liaison between emergency department, clinical staff, and patients/families. Identify opportunities to improve the patient's experience.
- Maintain a level of communication that meets the needs of the customer. Follow up on every concern to ensure a resolution occurs that meets the patient's expectations.
- Receive and provide customer feedback.

Other responsibilities

- Coordinate with patient relations as needed (chaplain services, interpreters, notary, advance directives, etc.).
- Follow infection control guidelines for patient and personal protection.
- Initiate interactions with patients and families that result in feelings of care, concern, and comfort.
- Understand the value each person brings to the team.
- Demonstrates belief in the value of individual contributions to the team's success and customer excellence.
- Perform other tasks per direction of the director or coordinator.
- Offer assistance to team members to meet patients' care needs.
- Be flexible and willing to rotate through the various locations in the emergency department. ■

The follow-through provided for those who come in through the ED and are admitted to an inpatient room is particularly effective from a patient satisfaction perspective, Royster says. "It's a nice thing, seeing a familiar face that they saw in the ED, not just for the patient but for the family.

"From the staff satisfaction perspective, it's also very good for the patient flow representatives," she adds. "In the ED, [typically] you may work with someone for six or eight hours and never know how they are after admission."

Under the guidelines of the Forsyth program, if a patient flow representative works with a patient in the ED who is ultimately admitted to the hospital, the rep tries to see that person every day until discharge, Royster says.

ED patients who are flagged to be admitted may start that process in the 10-bed emergency admission unit, where initial orders are carried out and inpatient beds may be requested, she notes.

If patients receive care in the unit, a patient flow rep follows them there and explains its purpose, Royster adds. Because the unit is located just off the ED, she says, patients otherwise might feel they are not making progress.

Patient flow reps don't stay with patients the entire time, she says, except during codes or traumas, when they are there "100% all the way through. That's part of the documentation that Andrew looks at for quality review and provides feedback on. [Staff] need to go back [and check on the patient] at least every hour, depending on the situation."

Consistency is key

The actions taken by the patient flow staff are monitored closely to help ensure the consistency and effectiveness of the program, Royster says. "We do a lot of documenting as to what steps they are taking with patients: Are they following our script? Are they introducing themselves the same way, describing the process the same way?"

Cox looks at such things as whether patient flow representatives are "throwing acronyms around" without explaining them. "Our hospitalists, for example, are called 'IPOFs' [internal physicians at Forsyth]."

Also noted, Royster says, is what steps are taken that could be characterized as "customer service," such as providing food or calling the chaplain, vs. those that are considered "patient flow intervention," such as working with environmental services to get a room cleaned STAT or contacting radiology or the laboratory to get results for a physician to review.

If they had it to do over, Royster and Cox say, they would have established the ground rules of the patient flow program with ED employees much earlier.

"It was an early challenge, making sure clinical staff knew who we were and when they should call us," Royster notes. "There was collaboration with them from the start, but when it got down to, 'When do you call me?' or 'When do you get involved?' we could have [clarified] that earlier."

Focus throughput, not customer service

"Early on, [patient flow reps] were doing more customer service-focused things, like getting blankets, but we wanted our focus to be on patient throughput," she explains. "We had some early issues with [clinical staff] wanting the patient flow team to take care of complaints and complete service recovery. They would call us and say, 'I've got a complaint — can you take care of that?' So we are clarifying for them, 'This is when we get involved, this is when we don't.'

"While we certainly do customer service activities, like getting blankets and escorting guests to our gift shop," Royster adds, "we set up the team to impact patient throughput."

Two months or so into the program, Royster and Cox did a presentation on the patient flow program to educate hospital leaders. "That helped us a lot," she notes.

In addition, new ED supervisors now meet with Cox as part of their orientation pathway to learn about the program and who the staff are, Royster says.

"About once a month," she adds, "we meet with the director and nurse manager of the ED to share experiences and get their thoughts on how we can be more helpful. Even though patient flow staff report through patient access, they really straddle the fence, as far as also being part of the ED staff."

With that in mind, Royster notes, patient flow staff attend staff meetings for the ED, as well as for the access department.

So that the patient flow team can be easily differentiated from ED clinical staff, members are required to dress in business casual attire or to wear polo shirts bearing the hospital logo and the words "Forsyth Medical Center Patient Flow Team," Cox notes. "If you have scrubs on, [people think] you're automatically a nurse or physician."

Patient flow employees also carry business cards with an e-mail address or telephone number, Royster adds, "so if a family member or patient needs to talk before we check back with them, they can contact someone."

Team members are 'designated requesters'

As an added service, seven members of the patient flow team have taken a class that allows them to be "designated requesters" for organ and tissue donation, she says, and an additional three were to receive training in December.

"If someone dies in the ED, whether from age or trauma, and we feel the person is a candidate, we will approach [the family member] and talk to them," adds Cox, who has received the training. "This is a huge help to the ED supervisor, because [the process] is very time-consuming."

People considering the option often have a lot of questions, he says, and patient flow staff can take the time to "get very in depth, very detailed." It also helps, Cox points out, that family members become familiar with the patient flow employees — which increases the comfort level — because they are so visible throughout the hospital experience.

Before patient flow staff took on this role, the responsibility for facilitating organ and tissue donation fell to the nursing supervisor, who had to handle it in the midst of myriad duties, he explains.

"[The nursing supervisor] would go in and talk to the family, get the paperwork on the record of death, and call Carolina Donor Services, which would call back and tell them if the person is eligible," Cox says. "By the time that call came, a lot of times the person [who could make the decision] had left."

Further discussion regarding the potential donation would then have to be done by telephone, he notes.

With patient flow representatives who have been trained as designated requesters handling the task, the turnaround time between making that call to CDS and having the agency call back with a response has been greatly reduced, Cox adds.

"When we place the call," he adds, "we already know what is required [for a person to be a donor]."

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How often is too often to ask for data update?

Providers balance accuracy, customer service

In the precarious world of checking information for patients who have been to their facility before, hospitals often juggle two important considerations: data integrity and customer relations.

"Patients are notorious for not giving good information and for information going stale," notes **Pete Kraus,** CHAM, business analyst for patient accounts services at Emory University Hospital in Atlanta. "They can have regular Medicare one month and move to an HMO the next. But if you grill them each month, you risk hearing, 'But you already have that.'"

In fact, he adds, patients may give that response even if their information *has* changed, and it comes up in subsequent conversation that, "Oh, yeah. I moved."

Some hospitals advocate full interviews at each patient encounter, while others let it go until the next week, or the next month, or longer.

This apparently no-win situation is one that technology has both helped and hurt, Kraus points out. It helps in that the information is retained, he says, but it hurts because patients' expectations are now that hospitals already have the data they need.

"Some patients really resent being interviewed over and over, even if it turns out something really needed to be changed," Kraus adds. "But if you let it slide, you have incorrect billing, wrong insurance, returned mail."

At Wake Forest University Baptist Medical Center in Winston-Salem, NC, previously collected patient data are brought forward if they are less than 90 days old, but registrars still verify the information with the patient if he or she is available, notes **Keith Weatherman,** CAM, MHA, associate director for patient financial services.

If the patient is not available, Weatherman says, "we will depend on the information."

His facility is in the process of implementing technology that will verify in real-time the patient's insurance, for most payers, as well as the person's address, he says.

"For self-pay patients," Weatherman adds, "we will continue to do a daily batch run to [a vendor] that bumps the names up against the Medicaid databases of all 50 states to see if there is a hit. We

also send our Medicare patients through the batch to find out if there is a Medicaid secondary [payer]."

Automated 'day sheets' are patient pleasers

The Woman's Clinic in Boise, ID, uses a simple but efficient way of updating patient information that automates the process for employees, makes it easier for patients, and improves data integrity, says **Lena Sears,** patient billing supervisor.

While updating patient data is critical for any provider, she points out, the task is even more challenging for a women's clinic, as these patients are the most likely to have a name change, or in the case of obstetrics patients, for employer data to change as the women juggle career and family.

The Woman's Clinic has two sites, Sears notes, with the main location serving an average of 300 patients a day for physician and nurse practitioner visits. The second site averages about 75 patients a day.

Responding to patients who "really dug in their heels" when asked to manually fill out an entire data form, she explains, the clinic's scheduling supervisor and an information technology employee collaborated with the practice management system vendor to come up with an alternative.

Their solution was computer-generated "day sheets" that print out the day before scheduled patients come in for their appointments, Sears says. The sheets, which contain existing patient data in the left column and a blank, lined right column, are inserted into patient charts.

Information is updated every 90 days, she adds, so the computer records the date when a sheet is issued to a patient, and automatically repeats the process for the next appointment that occurs after a three-month period.

"When patients check in, they are handed those sheets, and asked to make any changes on the right-hand side," Sears notes. "They complete only the portions that have changed and sign the bottom of the sheet. One copy goes in the chart and another is used for data entry."

In addition to serving as a tool to update patient data, the form also incorporates patient authorization information, so patient authorization signatures are kept current, she says. That part of the form also notes that the patient understands that charges incurred are his or her responsibility, regardless of insurance status.

Until recently, the clinic kept hard copies for 90 days, but now employees simply scan the sheets into a document management system, Sears adds. "In case there was a breakdown of the practice management system, we would have the information."

As long as the sheets print out each day as expected, "it's a great method," she says. "Sometimes we have little computer glitches and they don't print out."

A problem also may occur when a patient cancels an appointment and the signature date stamp isn't removed from the system, Sears notes. In that case, the computer record shows that an update has just been done, so the system won't print a sheet for the rescheduled appointment when the patient comes in a week or so later.

"It becomes critical to have those dates removed if there are no-shows or cancellations," she says.

"Typically, what happens is as staff go along through the day, if there is a no-show, they take the day sheet that has been printed and go into the system and delete the date. But sometimes they get busy, or the sheet gets set aside."

The automated day sheets are "a very simple concept," Sears notes, and one that works for the clinic. "The thing you have to be cautious about is that sometimes it's easy for the patient to scan through and say, 'Oh, yes, everything's the same.'"

While those cases typically are caught on the back end, she adds, there are times when they get by, and staff find out later there is new insurance, or the woman is no longer working so her husband's insurance is primary.

From her perspective as billing manager, she "sometimes would say that every 90 days is not often enough," Sears notes. "That's only because you have patients who come in November and then again in January, when they have all new insurance. So you can get caught between some crucial timeframes and not get updated information."

Arm staff with advance knowledge

Looking past the "how often is too often" debate regarding the confirmation of patient data, **Shawn Glinter,** RN, MBA, contends that "it's not good enough to simply ask patients to verify their demographic information."

"It's important to realize that when patients come to the hospital, the last thing they worry about is paying the bill," adds Glinter, a former access director and revenue cycle management consultant who now works for a health care tech-

nology company.

The stakes are too high, he suggests, for providers to depend on anything less than a proactive approach that encompasses people, process, and technology.

"[Providers] have policies, but in general they're very lax on all three components of their policies," Glinter says. "You've got to empower staff, give them the ability to make decisions, but also give them the tools to do so." **(See related story, this page.)**

"If you're going to bill a patient, for example, you want to make sure you actually verify that the address is correct," he contends. "In some states, you have to make sure that you've documented that record."

He cites an instance in which a hospital went through the entire billing and collection process with a patient, ultimately tracking down the person and talking about possible legal action, only to find out that for many months it had been sending the correspondence to the wrong address.

"That turns a situation very bad," Glinter says. "The hospital and patient [ultimately] worked it out, but it turned into a public relations problem and the hospital wrote off the entire bill because they had made this huge error."

One of the things he recommends is address verification software. "If you're a good, paying patient and you've been to five different departments and been asked for the same information, that's where technology is important."

Having the software in place is important, he adds, but so is teaching staff how to ask the questions. In many cases, Glinter says, patients perceive that registration staff are just going through the motions.

With the combination of a good process and technology, he suggests, the registrar might say something like, "I see you have given us this address, but if I run it through, a different one comes back. Have you ever lived at this address?"

"Explain to [patients] that you want to ensure that you have the most up-to-date information in case you have to reach them," Glinter says, "rather than, 'We need this to bill you.'"

Another effective tool, he notes, is having a way to flag the account so that registrars are alerted, during the registration process, to the fact that this patient has been in during the past 15 days and had his or her information verified.

In some cases, Glinter points out, it's not good enough to just have address verification software in order to bill correctly.

"Say you have a 21-year-old student who's handed you an insurance card and tells you he lives in the college dorm," Glinter says. "If you have an integrated product that is interfacing with the registration system, you want it to give you an alert message to have that registrar verify the guarantor of the account: 'What's the address of the parents?' Then all the bills and correspondence go to them, rather than to the dorm."

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Proper tools needed for collections work

Some hospitals 'shooting from the hip'

The right combination of people, process, and technology is particularly crucial when it comes to managing collections and charity care procedures, notes **Shawn Glinter,** RN, MBA, a former access director and revenue cycle consultant who now works for a health care technology company.

Asking for money in a patient-friendly way is the second-hardest job, contends Glinter, who is based in Nashville, TN. The hardest, he says, is being an emergency department (ED) registrar.

"It's hard for those on the front to do their job," Glinter says, "and while there's nothing better than real world experience, they can never be prepared 100% of the time. That's why it's critical to do training and have policies written."

In the designation of charity care and financial aid, for example, "some hospitals have very solid policies and some are shooting from the hip," he says. "Even with policies based on federal poverty guidelines, [at some hospitals] I guarantee you can get two types of discounts from two different financial counselors.

"It's OK to empathize, but you have to have processes in place," Glinter adds. "You don't want staff making decisions based on how they feel that day."

There have been several cases throughout the country in which hospitals were fined for hav-

ing poorly defined and inconsistent charity policies, he notes. "The answer is not to wipe off somebody's bill every time. You need to be able to show the criteria used in making that decision."

Simply telling financial counselors they can give between a 15% and 40% discount on a bill puts them in a difficult situation, Glinter suggests. "There's got to be training and you have to use technology [to get] good data and something to validate that decision. You give them the ability to make decisions, but you also give them the tools to do so."

There is software, he says, that allows a query to go out — during the course of a registration — on how likely it is that the patient will pay his or her bill. Using the person's name, date of birth, Social Security number, and address, this "prediction of payment" software looks not only at credit scores, but at the complete financial health of the patient, Glinter adds. It then reports, for example, that there is "medium likelihood" of payment from a particular individual.

There are guidelines, he explains, suggesting that this person be asked for an initial payment of $150 and then be set up on a $50-a-month payment plan.

In some cases, he notes, the software may indicate that the person is not likely to ever pay the bill, as well as whether he or she meets charity care guidelines.

At whatever stage the conversation about payment is occurring — on the phone during the scheduling process or in person at the hospital — it's empowering for registrars to talk about fees and deductibles and the possibility of financial aid with this information in front of them, Glinter says.

"One reason we get perceived as providing bad service is that we don't have confidence in asking for money and so we are hesitant," he adds. "If we give [employees] the right tools, they're more secure and have more confidence."

The payment likelihood information also allows providers to use their collections resources more efficiently, Glinter notes. "Hospitals spend a lot of time going after patients with a low likelihood of payment."

On the other hand, he says, "I have witnessed patients who had the ability to pay in cash say they were self-pay and couldn't afford the bill. You can't assume."

[Editor's note: Shawn Glinter can be reached at (615) 491-3270.] ■

SHHH takes NY hospital 'back to the basics'

Patient complaints sparked effort

To enhance patients' satisfaction levels — not to mention their ability to rest and heal — Montefiore Medical Center in Bronx, NY, has gone "back to the basics," says **Elodia Mercier**, RNC, MS, ANM, administrative nurse manager.

Evoking the time of Florence Nightingale and the image of a nurse raising a finger to her lips and whispering, "Shhh," the hospital has taken aim against the rising decibel levels of modern health care, she explains.

"We have so much new technology and equipment, which is a great thing, but sometimes we forget the concept of the quiet zone, that state of quiet that was part of providing care."

A program called Silent Hospitals Help Healing (SHHH) came about because of patients expressing concern — both in conversations and in Press Ganey patient satisfaction surveys — that the hospital was getting too noisy, Mercier says. "Since it was important to the patient, it was important to us."

In an effort spearheaded by Mercier, who works in one of Montefiore's med-surg pavilions, staff began to identify the barriers to a quieter environment and how to tackle them, she adds. "The goal was not to eliminate noise — that's impossible — but when possible, to reduce noise."

The No. 1 complaint, employees discovered, was about the sound made by the heavy metal hammer-like pill crusher, especially when it was used in the middle of the night. Now, Mercier says, nurses use a small, hand-held pill crusher instead.

Nurses complained that the cart taken around to check patients' blood sugar "sounded like the 'D' train going through at 5 in the morning," she says. "It would wake up the whole floor. The wheels were horrible."

When she asked nurses why they put up with the disruption, Mercier adds, the answer was, "It's always been like that." A trip to the bioengineering department, however, resulted in new wheels and a lube job, and that problem was solved, she says.

"It's simple, basic things," Mercier says. "Some

physicians and nurses were wearing clogs that made a clicking sound in the hallway, and they converted to soft-sole shoes."

Much of the problem was due to what she calls "the cocktail-hour effect," where overhead pages are being broadcast, alarms are going off, and staff are talking louder and louder because they can't hear each other.

When four patients are in a room and each turns up the volume on the television in order to hear over the other person's TV, the result is "four TVs blasting into the hallway," Mercier notes. The simple solution: headphones for the televisions.

To reduce the intercom noise, she says, the hospital now has two systems — a major one, used for announcing cardiac arrests, and an individual intercom on each nursing unit. "With re-education, the secretary now knows to talk in a low tone of voice."

Plans are to eventually have a Star Trek-style system, Mercier says, whereby nurses can hear their own pages individually, rather than having them announced throughout the unit. Another noise-reducing change has been setting beepers to vibrate, she adds.

Previously, Mercier says, the nursing floors often reverberated with the sound of keys jangling interspersed with people yelling out, "Who has the keys?" as nurses took medicine from the narcotics cabinet. Now the hospital has a computerized system that allows nurses to punch in an individual access code and take out the drugs that are needed for their assignment of patients.

Reducing that kind of noise, she points out, allows clinicians to better hear the ambient sounds — such as a ventilator alarm or an air mattress alarm — that help them take care of patients.

Reducing the decibels

In 2004, the hospital began monitoring decibel levels on a monthly basis, Mercier notes. For comparison, the noise from a train or motorcycle is about 95 decibels, and the decibel level in a library is about 50, she adds. "Sometimes in certain hospitals at the change of shift, it can go as high as 113 decibels."

From a starting point of between 90 and 115 decibels (equal to the roar of a subway car), Montefiore has reduced its noise range to between 55 and 60 decibels, as measured by the hospital staff using sound-measuring devices, Mercier says.

"We have been working aggressively to maintain this, and the staff are doing a wonderful job," she says. "To get patients and families to buy in, we have buttons that we like to hand out. Instead of saying, 'You have to be quiet — we have a SHHH program,' we say, 'We have a SHHH program on the floor, and we want to provide you with very good care. We will make you an honorary member for helping us with that program by using headphones for your television.'"

In the admissions area, Mercier says, there is likely to be a television on as a service for customers, and perhaps a radio as well. "When you add the noise from different offices and from staff coming in, laughing and having a good time, the noise level can be quite high."

Staff can help create a calmer and more restful environment for patients who are waiting for service by simply "toning it down," she suggests. "Walk up to each other and talk as opposed to yelling across the room."

To kick off the SHHH program, Mercier notes, the hospital held a contest to choose the design of a promotional poster and button. The winning entry, she adds, showed a close-up of someone's mouth, with a finger over the lips, and the words, "Quiet, please. Silent hospitals help healing."

Now there is a huge copy of that poster on the elevator that goes to her floor, Mercier says. "I didn't think people paid much attention to it, but one day I was in the elevator and a gentleman got in with his son, who was talking loudly and making a lot of noise.

"The father looked down at the boy and said, 'Patients are healing, we have to talk quietly,'" she recalls. "That made me feel really good."

(Editor's note: Elodia Mercier can be reached at emercier@montefiore.org.) ■

Survey: LEP programs lack resources, funding

Only 3% receive any reimbursement

While 80% of hospitals frequently treat patients with limited English proficiency (LEP), only 3% receive reimbursement for provid-

ing translation and interpretation services, according to a survey conducted by the American Hospital Association's (AHA) Health Research & Educational Trust (HRET) affiliate.

About one in five U.S. residents speak a language other than English at home. Hospitals responding to the survey reported encountering a wide variety of languages, including Spanish, Chinese, Vietnamese, Japanese, and Korean. At least 20% of respondents frequently encountered 15 of the 32 languages included in the survey.

The most frequent barrier hospitals faced in providing language services, the survey found, was that staff had no means of identifying patients who needed language services before they arrived at the hospital. That concern was followed closely by concerns over cost and reimbursement for providing language services.

Virtually all hospitals are required to provide language services to patients with LEP under Title VI of the Civil Rights Act of 1964, says **Steve Hitov,** JD, managing attorney for the Washington, DC, office of the National Health Law Program (NHLP). His organization, as an outgrowth of its National Language Access Advocacy Project, engaged AHA's research affiliate to conduct the survey.

Title VI says that recipients of federal funds can't discriminate against people on the basis of race, religion or national origin, Hitov says, and "national origin" is considered to include those with LEP.

Of the 3% of hospitals that do receive reimbursement for providing interpretation and translation services, 78% say that reimbursement comes from Medicaid.

There are 13 states for which Medicaid will pick up some of the tab, Hitov explains. "That doesn't mean it is adequate reimbursement, but if claims are submitted properly, they will reimburse."

Additionally, in some states there are pools of state dollars that are designated for language services in the health care arena, he notes, "but nobody is getting their costs covered."

Providing interpreter services is a very large expense for Chicago's Swedish Covenant Hospital, which is located in one of the most diverse neighborhoods in the country, says **Gillian Cappiello,** CHAM, senior director for access services and chief privacy officer.

Those services, she adds, include on-site interpreters employed by the hospital, a telephone language line, bilingual staff competent in providing medical interpretation, and having patient consent forms and other documents translated.

The vast majority of survey respondents are connected with telephonic services for interpretation, says **Romana Hasnain-Wynia,** lead author and HRET vice president of research, and are "trying to work out if it's possible to have staff interpreters, trying to find mechanisms to do that."

"We didn't ask a lot about organizational structure, but we did ask whether staff interpreters were available," she notes. "Part of the reason was if there are staff interpreters, usually there is an entity responsible [for oversight], and 68% said they have staff interpreters."

In another study that HRET conducted with the American Medical Association called Promising Practices, Hasnain-Wynia adds, "we wanted to find out the common denominator shared by hospitals that are effective in providing high-quality language services."

"The key element for the eight that received recognition was a charismatic leader who really took the issue on, usually someone who was director of language or interpretive services," she says.

Cristina Krasny, manager of interpretation and translation services at WakeMed Health and Hospitals in Raleigh, NC, described her hospital's efforts to improve services for patients with limited English proficiency, recommending all hospitals appoint a staff person to oversee interpretation and translation services.

"Without a dedicated staff person, a hospital will not be able to develop a language-assistance program that touches every aspect of the organi-

zation, from signs and maps to interpretations and staff training," she said.

Many hospitals reported that they need additional resources, tools, and training, says Hasnain-Wynia. When asked what they would find useful, she notes, 70% said they "really wanted training to help them respond in a culturally competent way to those who do not speak English."

One of the principles of the coalition of groups that came together at the invitation of NHLP to advocate language access, Hitov points out, is that since the federal government decided — with Title VI — that service to people with LEP is worth pursuing, it's worth paying for, and shouldn't exist as an unfunded mandate.

"As an advocate, I believe that it is a mandate [either way]," he adds, "but everybody knows it will happen more readily if it is supported. Hospitals are businesses.

"The entire group has signed on to the principle that it is the goal and obligation of society, as a whole, to pay for this — not just from the civil rights perspective, but because it also directly impacts the quality of care people receive."

A report by the Boston-based Access Project that was cited in the survey found that 161 uninsured patients who received health care at 23 primarily safety net hospitals had differing experiences based on access to an interpreter. Patients who needed and got an interpreter rated their hospital experience and the care they received more positively than patients who needed an interpreter but did not get one.

It was also noted in the survey report that in January, the Joint Commission on Accreditation of Healthcare Organizations instituted a new standard requiring hospitals to collect and document language information about their patients as part of its accreditation process.

In a recent development designed to facilitate communication with patients with LEP, an advance care directive developed by the Aging With Dignity organization has been released in 20 languages.

A CD with sample copies of the document will be sent to hospitals and hospices by a collaborative that includes the United Health Foundation, Aging with Dignity, the American Hospital Association, and the National Hospice and Palliative Care Organization.

In addition, 100,000 language-specific versions of the directive will be provided free of charge to individuals and community organizations. The "Five Wishes" directive meets the legal requirements for an advance directive in 38 states. ■

Uncompensated care costs increase 25% since 2000

U.S. hospitals provided $28.8 billion in uncompensated care in 2005, up from $26.9 billion in 2004, according to the latest American Hospital Association Annual Survey of Hospitals.

The survey measure includes charity care and bad debt, valued at the cost to the hospital of the services provided. The amount of uncompensated care provided by hospitals has increased by $5.3 billion, or more than 25%, since 2000.

Medicare and Medicaid payments to hospitals continue to fall below their costs of providing those services. According to the survey, Medicare and Medicaid underpaid hospitals by $15.5 billion and $9.8 billion, respectively, in 2005, up from $1.4 billion and $2.6 billion in 2000.

Nearly two-thirds of hospitals received Medicare payments less than cost, while more than three-quarters received Medicaid payment less than cost. ▼

COMING IN FUTURE MONTHS

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Barriers to EHR use described in study

Financial, technical, and legal barriers are keeping many physicians and hospitals from adopting electronic health records (EHRs), according to a study published online by Health Affairs (www.healthaffairs.org).

The authors, from Massachusetts General Hospital and George Washington University, found insufficient data to determine hospital adoption trends, but said best estimates indicate only 5% of U.S. hospitals have implemented computerized physician order entry, the best indicator in existing surveys for EHR use.

The report, funded by the Robert Wood Johnson Foundation and National Coordinator for Health Information Technology, found only one in four physicians use EHRs. The authors said improved definitions for EHR and "adoption" are needed to better measure adoption trends. ▼

CDHPs reduce care use; It's not clear if they deter it

Consumer-directed health plans can reduce health care use and lower costs, but it's not known whether these high-deductible plans also will deter people from getting needed care, according to a recent study by RAND Corp.

"The evidence from early adopters of these plans and similar changes in health insurance shows that greater cost sharing leads to reductions in health care use and expenditures," says lead author Melinda Beeuwkes Buntin.

"We know people are going to reduce their use of health care under these plans," she adds. "But what we don't know is how this will affect overall health care quality and patients' health."

RAND plans to address that and related questions as part of a four-year, $4 million study co-sponsored by the California HealthCare Foundation and Robert Wood Johnson Foundation. ■

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