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Amidst chaos from tornado, 'everybody worked together'

Registration staff moved smoothly into 'downtime procedure'

When admitting and registration supervisor **Tammy Wellons** entered Sumter Regional Medical Center in Americus, GA, just minutes after a tornado ripped through the 143-bed facility, her first impression was that it looked like a scene from a horror film.

"It was dark, water was pouring in, the halls were empty, and then there would be 10 people coming down the stairwell, wet to their knees from the water, holding onto a mattress with a patient on it," says Wellons, who estimates she reached the hospital at about 9:45 p.m. The tornado hit between 9 and 9:30 p.m. March 1, according to news reports.

"When I got there, we had to walk [from a distance] to get to the hospital," she says. "There was a group of us who walked together. We had brought flashlights from home. They had to cut up and clear away trees to get the ambulances lined up to get to our emergency department."

People were "scared and screaming and all that, but everybody worked together, no matter what it was that needed to be done," Wellons recalls. "My staff [who were on duty when the tornado hit] were shaken up [and] said you could never imagine the noise and sound."

Moments after disaster struck, however, those employees segued seamlessly into the registration procedure designed for when computers are not operational, Wellons says. "As soon as the tornado went through, all systems shut down, our servers went down. That's when we started with the downtime procedure manual. I was able to get the downtime books out when I went in."

Copies of forms — for patient identification, HIPAA privacy acknowledgement, and consent for treatment — were ready to go, she adds, along with patient armbands and "plenty of clipboards."

Registrars filled out the patient identification sheets, had patients sign the HIPAA and consent forms, and placed an armband on each patient, Wellons notes. In addition to the registration forms, each clip-

board contained all of the pages of nursing notes. "Everything stays together and follows the patient all the way through. To make sure nothing gets misplaced, there is an account number on every sheet."

The process is set up so that every area that does registration has so many pages of "downtime numbers" to be used to identify patient accounts, she explains. "When we come back live, [clinicians] wait on us to get the patient information keyed in, but they don't have to look for an account. All they have to do is key in an account number and pull up the patient [information] and not worry about spelling the name right."

Having that procedure so firmly in place that it was second nature to employees enabled her department "to keep business going" in the midst of chaos, Wellons says.

"Every hospital should have a downtime procedure and manual that staff are very aware of, in case they have nothing else to work with," she advises. "What if you're in that situation for days or weeks? We all depend on computers a lot, but always remember, there could be a day when you don't have that computer."

By about 11 p.m. on the evening the tornado hit, ambulances "were lined up to help take our patients out," Wellons says. Also on the scene were physicians and other medical personnel from nearby towns, as well as Sumter physicians. "I can't even tell you where they all came from," she says.

"When it was all over, about 2 in the morning, the president of the hospital called a meeting and we all stood there and cried," she says. "We were thankful that none of our employees were hurt."

Temporary hospital erected

The Tuesday morning after the tornado hit on Thursday night, Sumter Regional put up a makeshift, "M*A*S*H"-style hospital, with a "hard-shell" ED and tented areas for lab and X-rays, and even a nursery — in case a pregnant woman came in who was too far dilated to be transferred, Wellons says.

"It's a pop-up hospital," she adds. "It has air and heat, water supply, bathroom area with shower, and a washer and dryer. It's like a funnel all hooked together."

Outside the entrance, Wellons says, was a smaller tent for registration and triage.

"Those we can treat and send home, we're doing that," she says. "We can suture people, but can't do surgery or anything like that."

Patients with more serious conditions were being transferred to several different facilities, all within an hour's drive or less from Americus, Wellons notes. In addition to Phoebe Putney Memorial Hospital in Albany, which took most of Sumter's evacuated patients immediately following the tornado **(see related story, p. 39)**, those included Columbus (GA) Medical Center, Flint River Community Hospital in Montezuma, GA, and Crisp Regional Hospital in Cordele, GA, she says.

Within a day or two of the opening of the

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Albany hospital responds when nearby facility hit

'We implemented our disaster plan'

When the call for help came through to the command center at Phoebe Putney Memorial Hospital in Albany, GA, staff began looking at the facility's census, says **Todd Braswell,** RN, BSN, MS, CEN, director of the emergency center.

The immediate response was to ask, "What beds are available? Who can be transferred?" Braswell adds. "We implemented our disaster plan."

The facility in need was Sumter Regional Medical Center in nearby Americus, GA. A tornado had ripped through Americus on the evening of March 1, killing two people, destroying parts of the hospital, and severely damaging more than 200 homes in the town of 17,000.

There were no immediate inpatient discharges from Phoebe Putney to make room for evacuees from Sumter Regional and other tornado-related admissions, Braswell says, although a few patients were discharged from the emergency department.

From the entire tornado incident, Phoebe Putney accepted 45 patients, which included emergency patients as well as the transfer of inpatients from Sumter Regional.

"We had a ready bed waiting for every inpatient transfer," he says. "They told us what they were sending, in terms of obstetrics, psychiatric, etc. We received a mix."

The evacuated patients came through the ED but didn't stop there, Braswell explains. They were routed immediately to inpatient beds and were assigned to inpatient physicians, he adds. "It made tending to emergencies easier."

Emergency Medical Service (EMS) technicians carried the patients to the nursing floor, he says. Those who were ambulatory arrived by bus, Braswell notes, and triage of those patients was performed in the EMS dock intake area.

Patients he describes as the "walking wounded" were taken to the admit/discharge unit (ADU), a small clinical area that is open Monday through Friday and used as a holding unit, he says.

"When we went into disaster mode, nurses came from the emergency center and inpatient areas to work the ADU," Braswell says. "We also had physicians who responded." ■

modular hospital, eight patients had showed up for their regular outpatient lab tests, Wellons adds. "Who would have thought that before the week was up, we'd be doing some of our regular lab work?"

Five days after the tornado hit, she describes the schedule she had just followed: "I went in at 7, left at 6, and took work home with me. I want to make sure we don't lose anything. I meet the staff every time we change shifts, and they haven't been [to the temporary hospital] yet. I want them to know where everybody is, and not be scared."

About 10:30 p.m. or so, she was getting ready to leave to meet the night shift, Wellons says.

Registrars normally assigned to the obstetrics unit, under a different supervisor, were temporarily working with Wellons' staff, she says. "I introduce everybody to each other and make sure they know who I am."

At that point, five days later, "our only contact is by cell phone," Wellons says. Business office staff, including insurance and billing personnel, had been moved to an off-site building that had not been damaged.

Sumter HealthPlex, an 8,000-square-foot facility that had housed X-ray and outpatient laboratory services, as well as Wellons' office, was completely destroyed, she says. "My office is gone and any files I had are lost." If the tornado had hit during business hours, "there probably wouldn't be any of us alive." ■

Tired of 'reactive' stance? Emphasize the good you do

Then ID areas of deficit, consultant says

A turning point in **Michael Friedberg's** tenure as patient access director at an inner-city, multi-hospital system came when he "got fed up" with the reactive management style.

"The problem faced is that patient access representatives are generally among the lowest paid and least formally educated personnel," explains Friedberg, FACHE, CHAM, a manager with Besler Consulting in Princeton, NJ.

Access representatives make an average of $12 an hour — just slightly more than hospital housekeepers and in the same range as Wal-Mart cashiers and pizza delivery people — yet are charged with a complex array of skilled tasks in which accuracy and confidentiality are key, he notes.

To adjust for that disparity, access leaders have become very reactive in their approach, Friedberg suggests. "If someone from patient accounting says, 'We have 12 accounts where the ID is wrong,' or 'The nephew of [a VIP] came in and you registered him as self-pay,' the access manager typically reacts to that by saying, 'We're dumb' or 'We got it wrong.'"

Tired of taking that stance, he decided to develop a system that would do two things — "emphasize the positive, good work we're doing and identify areas of deficit for increased training."

Access representatives, Friedberg notes, make errors for five reasons:

- They make "honest" mistakes, such as those caused by wrong keystrokes.
- They lack proper tools.
- They are not trained properly.
- Despite trying hard and getting lots of training, they're just not right for the job.
- They don't care about their jobs and have no pride of ownership in their work.

"The ones who don't care, the lack of training and tools, are all easy to address," he says. "There is a way to address keystroke errors, but you can't fully eliminate them.

"The hard ones," Friedberg adds, "are when you realize at a certain point that it just won't happen for them — but those are few and far between."

As part of becoming more proactive, he says, patient access managers should create a set of key indicators that are reviewed regularly by hospital leaders both inside and outside the access area. **(See related article, p. 41.)**

Along with being reactive as opposed to proactive, access leaders also "never really build in accountability," he says. "Even if a mistake made on an inpatient account costs thousands of dollars in delayed payment, or because a payment is not received, [the person responsible] is not usually notified of the error. It's just a black mark on the whole department."

With that in mind, Friedberg says, he made

The Approach Evaluation Tool

Registration Quality Assurance
Checklist

Patient Name: _____
Account Number _____

Standards	PTS	Yes	No	Standards	PTS	Yes	No
1. MPI Addition	5			8. Insurance Selection & Insurance Information	15		
2. ID/Ins Card Copied/Proof of Address	10			9. Insurance Verification/ Passport Eligibility	5		
3. Account Notes (Proper Documentation)	10			10. Insurance Precertification/Referral/NOA	10		
4. Patient Name and Demographics	10			11. Charity Care Application	5		
5. Guarantor Information/Relative Information	10			12. MSP Questionnaire	5		
6. Dept Loc/Adm Type & Source/Arrival Mode	5			13. Physician Selection	5		
7. Diagnosis/Hospital Service	5			**Total Points**	**100**		

Comments:

If not applicable, please assign Yes points.

Total Yes Points Scored _____

Source: Besler Consulting, Princeton, NJ.

accountability one of the cornerstones of his quality assurance (QA) program, but with a positive approach.

Getting away from the defensive stance that access leaders often take, Friedberg put the emphasis on the things his department was doing right, he says. "One example: The medical records director catches the CFO in the hallway and says, 'Last month, the access people created 75 duplicate medical record numbers, and each of those cost us an hour of work.'"

When the CFO e-mailed him, asking what he was going to do about the problem, Friedberg recalls, "My proactive approach was, 'Yes, we did that, but we've also started to notify [the medical records department] when we know we've made a mistake, rather than waiting for it to be found, which is why more [duplications] have been reported.'"

Additionally, Friedberg pointed out to the CFO that the access department created 15,000 medical records during one month, and that 75 — or 0.5% — duplications was not a bad error rate.

"I told him that we are always striving to do a better job, but that other matters required my more urgent attention," he adds. "I didn't hear from him again."

QA, training 'hand in hand'

In designing his QA and training program — "they go hand in hand," he emphasizes — he took 15 specific items within the registration process and weighted them to total a 100-point score. "Most, but not all, of the items were related to billing. Picking the right insurance carrier and plan was more important than the Medicare Secondary Payer questionnaire, although both are important." **(See checklist, p. 40.)**

"Then we started to review a minimum of 10% of registrations for each registrar," he adds. "Using Excel spreadsheets and roll-up reports, the overall score and areas of deficit were obvious quickly, by department and individual."

There is also a quantity score, which looks at the number of registrations done in a month divided by the hours worked, Friedberg says. "That number is not the number of registrations they can do in an hour, but is a number you can use to compare people in similar departments and on similar shifts."

Work done by a registrar on the 3-11 shift in the emergency department, for example, is compared to work also done on the 3-11 shift in the ED, he says.

"We were able to get interesting data, and we were able to create interesting questions," Friedberg says. "In some cases, it was easy to see where the deficits were, and we created training classes to address those. We were able to make comparisons, create standards, and initiate accountability."

In all cases in which he used the program, he notes, "the percentage of clean claims went up, the denials went down, and the reputation of the

Look at 'key indicators,' anticipate areas of concern

'No need to wait' for VP's call

One important way to take a more proactive approach to managing an access department is to create a set of key indicators that are reviewed daily, weekly, and monthly, says **Michael Friedberg,** FACHE, CHAM, a manager with Besler Consulting.

"Some call them 'scorecards' or 'daily dashboards' or 'KPIs' [key performance indicators]," he adds. "If you look at the same set of indicators every day as a manager, you will begin to notice trends or 'normal values' in the data.

"If you see variation to those 'norms,' then you must begin to question if this is simply an outlier or if it is a trend due to a change," Friedberg notes. "For example, if you routinely measure patient wait time to be registered in your area and it has been seven to 10 minutes for a consistent period of time, and then jumps to 14-17 minutes for a few days, this leads you to question why.

"Have you been short-staffed? Did you implement a new requirement? Did the volume spike due to some other provider discontinuing a service that you had to pick up?"

What he is suggesting, Friedberg continues, is that there is no need to wait until there is a phone call from the vice president of nursing to say that procedures are delayed due to a slowdown in outpatient registration to figure out why.

"You will get the phone call anyway," he adds, "but isn't it better to respond by saying, 'I am well aware of what is happening as I track this indicator daily; we have investigated, and here is what I am doing to address the problem.'" ■

How accurate are patient satisfaction surveys?

'Continual monitoring' brings best results

When it comes to quality assurance in the customer service arena, those patient satisfaction surveys that have become ubiquitous in health care may not be providing accurate feedback, suggests **Michael Friedberg,** FACHE, CHAM, a manager with Besler Consulting in Princeton, NJ.

"My feeling is that patient satisfaction surveys are potentially flawed," he says. "Many hospitals taint the process by preparing patients in advance of their receipt of the survey."

When he asked a recent gathering of health care professionals if they had a similarly negative opinion of such surveys, three-quarters of the hands went up, Friedberg adds. "I'm not convinced [patient satisfaction surveys] are an accurate representation of the service provided in patient access."

Among the more effective means of accessing managers and directors to measure customer service, he says, are to look at complaints to hospital administration and to create standard telephone scripts and then check to see if they are being used properly.

Since access is a 24/7 operation, that means calling late at night and early in the morning, Friedberg adds. "Many [access departments] have one or two access people on duty from 6 at night to 6 in the morning. If nobody is in charge, they can pretty much do what they want. You need to figure out a way to continually monitor them."

During his early years as a corporate director of access, Friedberg was also a new father. "When I gave the baby a bottle at 3 a.m., I also called all three hospitals. [Staff] used to hate that.

"Mystery shoppers also work very well for this," Friedberg adds. He recounts an example from his own experience in which a mystery shopper, pretending to be an existing patient, presented to his emergency department registration area.

"We expect our staff to re-interview [existing patients], especially in the emergency department," Friedberg says. "The mystery shopper reported that the registration representative did not speak to him during the process, except to ask his name, Social Security number, and date of birth."

The registrar then proceeded to hit the "enter" key all the way through the registration, asked the patient to sign in three places without any explanation, and then sent him on his way, he continues. "If a supervisor, manager, or director was in the area, [employees] would never show this behavior.

"Due to the 24/7 nature of patient access," Friedberg adds, "I would have to say that you must assume some of this is happening — especially on the third and first shifts, that is, 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. — but it is hard to prove." ■

department changed."

Theoretically, in the same system and using the same tools, the ED registrar at Hospital A should exhibit roughly the same registration quality as any other ED registrar in the system, Friedberg says. "If not, it doesn't mean one is bad and one is good; it just gives you the right questions to ask."

"Is one registrar too fast, one too slow? Is one slow but gets everything right, and the other going so fast to make up for [the slow registrar] that she is missing items?" In those situations, he adds, "you make proactive management decisions as well as create training."

As an alternative to processes like the one he developed, there are a number of companies that offer automated QA systems, Friedberg says. "There are advantages to both [manual and automated systems], but the advantage of the electronic is that you can audit 100% of registrations that way."

"The downside [of an electronic system] is that this work is sort of 'touchy-feely,'" he adds. "It can tell you that the insurance ID number is filled in correctly and is in the right format, but not whether it actually belongs to that person."

In the next six to nine months, Friedberg says, electronic QA systems will be available that can go out and check eligibility and other insurance information.

On the other hand, manual processes give departments the ability to be flexible, he says. "Different states have different requirements. I had a client in Pennsylvania, where the local Blue Cross Blue Shield provider was matching the subscriber name to whatever was submitted by the hospital and, if it was not an exact match, rejected it, saying, 'We don't know who that per-

son is.' That's the game they play."

In such instances, Friedberg advises, target the QA on that item.

In New York, there is something called a UT (utilization threshold) authorization for Medicaid patients, he says. "You have to get that number in order to bill. My New York client created that as a focal point.

"My feeling is that [access departments should] first of all, create accountability, and second, manage proactively as opposed to reactively," Friedberg emphasizes. "If you have the time and money to do an automated system, great, but anything is better than nothing."

When he first began speaking on the topic of quality assurance a couple of years ago, he recalls, 5% or 10% of his listeners might raise their hands when asked if they had a dedicated QA resource.

"Now about 50% of the hands are raised, but I question how effective those programs are," Friedberg says. "I have concerns about how they do it. I still say something is better than nothing, but those that do have something should look at how formalized it is.

"One person might say, 'Yeah, we review accounts — the supervisor eyeballs them,'" he says. "I just did a project where that happened, but when I looked at the accounts, at a variety of factors, I found a lot of things that were concerning."

One of the keys to a successful program is picking the right person to oversee the QA process, Friedberg says. "Good registrars do not necessarily make good trainers. [Trainers] have to be detail-oriented, outgoing, enjoy writing, and be accepted by the staff as a good registrar."

If you choose the wrong person, "it will delay or doom the program to failure," he says. "If you pick Suzie and everybody knows she is a bad registrar, it hurts the integrity of the QA process."

There are still many departments where the training of new access employees consists solely of having them sit next to a veteran registrar, but the tide is turning, Friedberg notes.

"Hospitals that have spent time and resources and increased staff in patient accounting departments have started to realize in the last five years that an equal investment on the front end is a good place to focus," he says. "It removes or relieves rework that accumulates on the back end."

(Editor's note: Michael Friedberg can be reached at mfriedberg@beslerconsulting.com.) ■

Access, CM functions overlap for patient needs

'How do you get a control point?'

The clinical expertise of case management is increasingly being used in the access process, and in the next five years many of the functions of the two disciplines will be consolidated, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner at the Center for Case Management in South Natick, MA.

"Case management staff are being asked to run the bed board, to have somebody in admitting and registration, to have a utilization review person doing preauthorization and precertification," Zander adds.

That overlap can only increase as hospitals and health care systems grapple with the many ways in which patients access care, she suggests, citing a client that is a well-known tertiary medical center in a rural area.

"There are patients admitted from the emergency department, direct admits from physician offices, acute-to-acute transfers, and people coming in on helicopters," Zander says. "How do you control all these doorways to your center? Who decides who comes and when and what bed to put them in? The ED is pushing for beds and post-surgical [staff] are pushing for beds.

"The challenge," she notes, "is, 'How do you get a control point?' Do you keep having a variety of ways to get in or do you consolidate it?"

Adding to that challenge is the fact that the process goes on 24 hours a day, and that it involves an intricate mix of medical, financial, and regulatory concerns, Zander says. "The more people see that these are clinical discussions plus regulation plus reimbursement, the more case management will start to influence the access piece."

"In the old days," she points out, "if you needed a bed in off-hours, the nursing supervisor would canvas the hospital, decide what bed was available, and the patient would go there. Now it's much more complicated. There's a higher demand for beds and for immediate decisions."

While she believes that access will take on much more of a clinical judgment role, Zander says there is no clear answer as to whether the top decision maker in the process will come from

the access or the case management arena.

"In my experience, the person that gets given this bigger scope is the person who has been successful in smaller scopes," she says. "The boss will be the person who has proved herself in other ways."

Zander says she could see a physician being part of access, especially at a tertiary medical center with direct admits.

In addition, she says she would like, in the case of a health system, for clinical and support people to have the authority to place patients in beds throughout the system, not just at the facility where the patients present.

"There is a very cumbersome process now, where an acute rehabilitation facility has to send a representative to the hospital, assess patients, and then go back and see if they really have a bed," Zander notes. "I see all the middle stuff being cut out and, through clinical judgment and criteria, [intake staff] saying, 'It's time for acute rehab'" and finding a place for the patient within that system.

That would be with the patient's permission, she emphasizes. "It all has to do with patient choice, but if patients choose that, and that's what they need, let's just get them there — or to a skilled nursing facility or home care [if that's what is needed]."

This could be a patient in the ED, or one currently in a bed, Zander notes, "but instead of having case management call agencies and say, 'Do you have a bed?' have one access person say, 'We have this bed [within the health system].' It takes a lot more personnel to have the process we have now."

Taking her access concept further, Zander says she advocates consolidating all of the entrance points — and the decisions on who can come into a hospital — in one department.

In addition to having bed booking available beyond the walls of the hospital, she says, functions such as transport would be centrally coordinated. In many health facilities at present, Zander notes, "if you need transport for a patient, the secretary on the maternity unit also covers that, and the admitting office covers something else, and there is an internal transport staff that take patients around inside the facility.

"If you think about the definition of access and how far you can spread that and how serious you can get about it, whole new models come to mind," she says. "It's like being the nerve center, like air traffic control. It's bed traffic control."

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'Cognitive load' increasing for health care workers

It's 'brain flow,' not work flow

Something called "cognitive load" or "cognitive work" is the centerpoint of some of the latest thinking on the way people process information and do their jobs.

That research — by Patricia Potter, a nurse scientist at Barnes-Jewish Hospital in St. Louis who co-wrote the textbook "Fundamentals of Nursing" — concerns nurses, but can be extrapolated to case managers and other health care professionals, notes **Karen Zander,** RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

"Pat is doing research with an industrial engineer," Zander says. "He is looking at work flow, but she is studying 'brain flow.' In clinical work, sometimes your body and mind are not in the same place."

The engineer measures when and where the nurses go, how much time they spend in each patient room, and whether they are charting or performing another task, she explains. Meanwhile, Potter is studying what's going on in their brains, what they are filled with as they go from place to place or while in one place, Zander adds.

"The idea is that you hold a lot in your head," she says, "and it's different from multi-tasking, which is eating a sandwich, talking on the phone, and reading something on your computer screen at the same time."

Cognitive load is about how many activities and distinct pieces of information a person holds in his or her head at any one time, Zander continues. "It's the thinking that goes into the doing, the assessment, and judgment that comprise critical thinking."

In "regular life," the cognitive load may have to do with thinking about how much food is in the refrigerator and an errand that needs to be done and being interrupted by a phone call, she says. "In health care, it's high-level stuff."

As part of her research, Potter tracks the number of shifts people makes in their cognitive work

as they go through the day, Zander says. "She's looking at how a nurse shifts from one to the other of four things: assessing, planning, implementing, and evaluating."

The findings were that a nurse had 82 shifts in thinking in eight hours, she notes. "When the nurse is in a room with a patient, and the patient is telling her about a pain in his side and she is asking questions, that's assessing. If she's starting to say things like, 'If you take deep breaths it might get better,' or 'I'll get you a pill,' that's implementing."

If the nurse goes back later and says, "Are you feeling better?" and "Can you walk now?" that's evaluating, Zander says. "If she says to another nurse, 'This seemed to work this time, but you might want to try another approach on the evening shift,' that would be planning."

In addition to the 82 shifts in thinking in eight hours, there were 42 interruptions, she says, after which the nurse had to return to her work. "That was a nurse with maybe five patients," Zander adds. "A case manager might have 15 or 20."

The industrial engineer concluded that the nurses spent an average of 30.9 minutes per patient room, she notes, but Potter found the cognitive work took another 15.7 minutes per patient, for a total of 46.6 minutes.

"[The cognitive work] is invisible to the eye, but it is the stress of what the work is," Zander says. "If that breaks down, if the person just can't carry all that in her head or can't get interrupted and go back, and loses focus, that's a safety issue."

Among the questions being addressed with the research, she says, are, "How do you restructure work, so there are fewer interruptions? Can something be reorganized so you can handle the load?"

After learning about this research, she has given more respect and attention to how much thinking case managers are doing about a case, Zander says, and has "gotten much less respectful of productivity studies. They don't prove anything about what's really going on with professional people and their work. That's not how we should be looking at the productivity of a professional person."

An appropriate question for those in leadership positions, she says, is "How can we cut down the variables for case managers, who are more mobile and have more patients than nurses?"

The popular book "Blink," by Malcolm Gladwell, says that the more experience you have, the faster you make your decisions, Zander points out. "Why fill out pages and pages of forms, when an experienced case manager can make a decision in an instant?

"Can we simplify the documentation and the forms we fill out, and yet know we are looking thoroughly at a situation? How do we find a balance and move forward without all the bureaucracy?" ■

'Patient portal' designed for elderly patients

Pregistration function to be enhanced

A University of Arkansas for Medical Sciences (UAMS) project that began with the Center on Aging identifying a need to communicate better with elderly patients has become an ambitious Internet initiative encompassing the entire campus.

The Center on Aging, one of the UAMS Centers of Excellence, wanted a way to get elderly patients more involved in their own health care, specifically through an exchange between institution and patient that would tie into the electronic medical record system, says **Alan Gardner,** MBA, director of process and planning for the UAMS information technology (IT) department.

After the IT department created a prototype for this "patient portal" — based on a list of functions submitted by the center — other UAMS institutions discovered what was going on and expressed a strong interest in becoming part of it, adds Gardner.

Among the functions included in the prototype were the ability to request and view appointments, a list of known medical conditions, a medications list, and a patient education resource center featuring web sites that the Center on Aging deemed good places for information on senior health, he says.

After the interest expressed by other campus departments — and the realization that a patient portal would be "a very visible component of UAMS" — the decision was made to include oversight and representation in the project from other key areas on campus, Gardner notes.

Project leaders would need to adapt the portal — which was designed for seniors — for broader

use, as well as address some issues that were specific to the elderly population, he says.

"Say there was a patient who couldn't care for himself anymore — someone with dementia — and the family had decided that they didn't want him to have access to information about all of his medical conditions," Gardner says. "They might have concerns about the patient knowing too much about what was going on and getting stressed out."

UAMS already has a preregistration component on its standard web site, he says, but as part of the new project "we will pick that up and enhance it and plug it into the patient portal."

As with the Microsoft Wizard, which "steps you through a process and does two or three little chunks at a time," users will be pretty sure they have answered all the preregistration questions correctly, Gardner says. "It will be a huge benefit for us on this campus. Today, if patients call for an appointment, many times we don't gather next of kin, address, and guarantor information. Information that is needed to submit a bill often is not included."

Staff will have the ability to send appointment reminders to patients via e-mail, with an instruction like, "Please click on this link to preregister."

Patients then will be able to easily enter on-line information they normally write by hand while sitting in the waiting room with a clipboard, he adds. "Our inpatient [department] provides this function over the web, but we want to make it more prominent. Now it is hidden behind screens and not many people are aware of it. We also want to include outpatients."

In addition, Gardner says, the preregistration function will be visually integrated into the patient portal, with identical colors and graphics.

One of the issues that surfaced regarding the design of the patient portal had to do with "secure messaging," a process whereby patients would be able to send a message — more secure than an e-mail — to a clinic or a physician, he notes.

The primary concern there, Gardner adds, was what processes need to be in place to make sure someone actually responds to such a message.

"We didn't want patients to send a message and not get a response for two days, or for a nurse to think a physician responded, and the physician to think the nurse did, and no one responded," he says. "There are downstream policies and procedures that need to be in place."

Contributing to those "downstream" issues is the way in which a university health care environment differs from its non-academic counterparts, Gardner points out. "We have tenured faculty that work in clinics 20% to 25% of the time, and otherwise are involved with surgery, classes, and research, so their direct patient interface time is much less than in the private world."

Within that scenario, he adds, "each clinic operates differently and has its own work flow that works best for its faculty."

At the large UAMS cancer research center, for example, patients may come in for treatment at 8 a.m. and not leave until 4 p.m., Gardner says, while the family medicine clinic sees walk-in patients who come and go in a short time.

Those differences may impact how information is entered into the medical record system, he says. "We don't have 100% participation in the EMR across the board. In some clinics, [staff] are putting notes into a laptop computer as they examine the patient. In others, they do the exam, go back to the office, write up the notes, and then scan them into the electronic system."

"If we're going to have a patient portal that allows patients to see discharge summaries and letters that have been written, and timeliness is good in some clinics and not good in others, patients will be irritated," Gardner adds.

Another example is how different clinic staffs handle prescription refill requests, he says. "Some collect them in the morning and when they catch the physician, say, 'Here are six — will you sign off on them?' Other physicians may prefer to get them directly. The point is that each clinic operates differently."

In view of those kinds of issues, and with the increased scope of the project, Gardner explains, the project steering committee decided to "step back, reassess the whole project, and then move forward with a more planned, enterprise-wide solution."

UAMS did a survey of its various departments to determine what functions they felt were most important to include in the patient portal, Gardner says, based on level of effort required to implement, as well as benefit to the patient and to the department itself in terms of cost-savings.

Survey results, he adds, included the following functions, in the order in which they were ranked by respondents:

- preregistration;

• prescription refill request;
• appointment request;
• medications list;
• appointment viewing;
• patient education resources or links;
• requests for medical records;
• lab test results;
• medical conditions list;
• on-line bill or invoice viewing and bill payment;
• clinical care team list;
• secure patient-clinic messaging, with the nurse, physician, or appointment desk, and the integration of that messaging with the EMR system;
• ability to update insurance and registration information;
• a wayfinding system that would be tapped into with the patient portal.

The project steering committee — a group of between 20 and 25 administrators, clinicians, and other interested parties that meets monthly — will determine what the policies and priorities are regarding the patient portal, Gardner says.

While there potentially are task groups for 15-plus functions, he notes, some of those likely will be combined — the medications list and the medical conditions list, for example.

Because of the downstream issues that are being encountered in some clinical areas, project leaders have decided to work first on the operational, administrative functions such as appointment requests, medical record requests, and bill payment, Gardner says. "We don't want to delay getting the portal out to our patient population because of all of the downstream policies [on which] we will have to get agreement and then institute."

Some of the clinical functions already are being performed with one large UAMS department, he notes, "but the way we implemented the functions for them may not be best for everybody."

The decision to offer functions such as refill requests and lab test results notification first was validated by his visits to other medical university health centers that have implemented or begun work on patient portals, Gardner says.

'Secure messaging' hot topic

"One of the most valuable things I've learned in that process has to do with secure messaging, which is a hotly debated topic. If you open up that pathway and respond to that message, there is no good way for the physician to get paid."

There also could be a liability issue, he adds, in instances in which the patient doesn't tell the whole story, gets advice from the physician, and later has complications.

"What I found out from other universities is that what they did is offer all the other functions first," Gardner says. "Those are the things patients usually ask about. Less than 3% of the questions [the other institutions] were getting actually needed to be forwarded to a physician."

Delaying implementation of the secure messaging feature "makes a world of difference," he adds. "Everything is more directed to where it is supposed to go, and you don't have physicians looking at an abundance of messages that someone else in the clinic is responsible for."

During his visits to the other facilities, he also "heard good success stories" about on-line collection rates, Gardner says. "At one institution, over a short period of time close to 30% of their patients were making electronic vs. check payments."

In addition to improving its own cash flow with on-line bill payments, UAMS thinks the patient portal will have the following benefits.
• improve patient satisfaction;
• get patients more involved in their own health care, in line with national initiatives such as consumer-driven health plans;
• reduce administrative costs;
• improve work flow through on-line preregistration and appointment requests.

(Editor's note: Look for more information on the UAMS patient portal, including the wayfinding function that will be implemented in a later phase of the project, in a future issue of Hospital Access Management*.)* ■

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NEWS BRIEF

Cost biggest barrier to health IT adoption

Hospitals continue to accelerate their use of health information technology, with 68% reporting that electronic health records had been fully or partially implemented as of fall 2006, according to the American Hospital Association's second annual survey of hospital health IT use.

About one-half of hospitals shared electronic patient data with others in both 2005 (53%) and 2006 (49%). Their most common partners included private-practice physician offices, laboratories, payers, and other hospitals.

Cost is the biggest barrier to greater adoption of health IT, with urban hospitals, teaching hospitals, and larger hospitals more likely to afford the investment, the survey found.

Forty-six percent of community hospitals reported moderate or high use of health IT, compared to 37% in 2005. Health IT use was determined by the number of clinical IT functions — such as medication order-entry, test results review, or clinical alerts — a hospital had implemented.

The AHA points out that while recent Department of Health and Human Services rules have lessened obstacles posed by the physician self-referral and anti-kickback laws, hospitals have been concerned that, under Internal Revenue Services rules, helping physicians access and use health IT could impact hospitals' tax-exempt status.

The latest indication from the IRS, according to the AHA, is that the new HHS rules would not jeopardize hospitals' tax-exempt status. ■

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