

Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END

Case study

Pricing estimates: Automate your process, boost your customer service ratings

It has been one year since the Bush administration issued an executive order to push providers and insurers to become more transparent about procedure pricing and reimbursement.

Savvy consumers who understand their rights as a customer—and their leverage in a consumer market—have begun to ask questions about pricing. In many cases, they are demanding an estimate.

But no matter how often your patient access staff explains the myriad of variables that could affect the bill that the customer must ultimately pay, the customer won't be happy if your ballpark guess winds up nowhere near the ballpark.

In 2006, officials at the Mayo Clinic took proactive steps to mend this process when they realized that their

manual approach led to time-consuming and inconsistent estimates.

"We had a significant growth in our self-pay volume, and we have a pretty high degree of folks who come here for a second opinion," says

Kelly White, section manager of PFS

patient services and special accounts at the Mayo Clinic in Jacksonville, FL.

"We realized quickly that we had to do a better job of price estimating. At the time, the accuracy was more than questionable," White says.

"Sometimes it took longer to create the estimate than to perform the operation itself."

—Kelly White

The impetus behind change

Before 2006, the Mayo Clinic, which is based in Rochester, MN, used a manual process to provide price estimates to customers. The process wasn't simple.

First, patient access staff would receive information from a surgeon that detailed what procedure he or she wished to perform. The staff translated that information into the right code. At the end of the month, staff had a printout, three-to-four inches thick, of all the procedures performed during the month.

When a request for an estimate came in, the patient access staff hit the books.

"They'd flip page after page to locate a few similar operations, and then they'd figure out an average of those charges," White says.

But this process could take as long as six hours, she notes.

"Sometimes it took longer to create the estimate than to perform the operation itself," she says.

Transparency hit Florida early as the state government



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Pricing estimates

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passed a law that said providers must supply a patient with an estimate within seven days of the request.

"The pressure was on for us to come up with a solution," White says.

A five-step wish list

At the time the Jacksonville campus decided to redesign its price estimation process, the Rochester campus was using an automated database. But that, too, was far from perfect.

"It was a maintenance nightmare," White says. "They had to make sure the numbers were correct, and that was very time-consuming."

Meanwhile, the Mayo Clinic in Scottsdale, AZ, was using the same database, but to save time, staff didn't perform manual updates.

"They would just tack on 8% for price increases. So it wasn't an exact science," says White. "All three sites have an opportunity to improve the way they provided estimates."

White helped put together an enterprise team in Jacksonville to develop the following wish list of five qualities they'd like in a software product:

1. Estimates based on historical claim information, not just from the information that the physician provides.

"The physician may say that he'll do a total hip replacement and that it will take him two hours, but in reality it took him five hours," says White. "We wanted the estimates based on the actual claims—what was actually going out the door."

2. The ability to add individual items from its charge description master.

"So if the physician wants to do an MRI, as well, you can just easily add that into the estimate," says White.

3. Customizable software. Because each Mayo Clinic site had to work with different regulatory issues, this feature was important. Additionally, the team wanted to customize the prices to the work of individual surgeons.

"One surgeon may complete a procedure in two hours, another in three. And one surgeon may prefer one more expensive supply over another," says White. "There were many variables."

4. The ability to provide the most accurate estimation at that time. "Rochester was only updating annually and Scottsdale wasn't updating at all, but we wanted the estimates to reflect the current increases and decreases in product prices," says White.

5. Software that could also help facilitate the quality assurance process.

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“We wanted it to show us what the variance was, and if an employee wasn’t translating the information correctly,” White says.

Finding a partner

With its list in hand, the team contacted other providers to see whether others had found a solution. But that search came up empty.

“What we found is that they were just like us, either using an automated database that was a maintenance nightmare, or they were using a manual process,” says White.

The team considered building the product internally but decided against it. The last option was to find a vendor with which to partner.

Accuro Healthcare Solutions, a revenue cycle software company, had recently purchased a majority interest in Innovated Managed Care Solutions, which performed the Jacksonville site’s contract management.

“We sat down with them, gave them our wish list, and agreed to work together to build a product,” says White.

Implementation phase

The Jacksonville site implemented the price estimation software in two phases—on the facility side and on the professional side.

The trial period lasted three months for each, and Jacksonville went live with the facility piece in April 2006 and the professional piece in January.

So far, the transition has been seamless, says White. The vendor receives the claims information electronically. When a patient access staff member searches the database for information on a specific procedure for a specific patient, the software quickly shoots back 25 patients with a similar age, physician, and insurer, and who underwent a similar procedure.

The professional pricing isn’t as easy, though.

“We’re multispecialty, so the physicians could perform all kinds of procedures in one day. Therefore, it’s harder to narrow down,” White says.

But it’s still much quicker. The software allows staff to provide an estimate in less than two minutes on the facility side and in five minutes or less on the professional side.

As a customer service benefit, patient access staff members provide patients with the high-end cost, not just the median cost or fee.

Administrative considerations

The Mayo Clinic wasn’t forced to reduce staff after implementing the pricing software. Instead, staff members are repositioned to maximize their efforts.

“Staff is working with the patient from the time they’re identified. They preregister, they preauthorize with the insurance company, and educate patients on their benefits,” White says.

White does expect her staff to use the additional time to focus more on up-front collections. Although the software has brought down the amount of money staff collects, White says that’s actually a good thing.

In the past, after patients complained that their actual bill was much higher than the given estimate, staff would pad the estimate. Now they don’t need to.

“So while collections decreased a little, our refunds decreased, too,” she says. “It’s hard to measure, but we’re collecting less, because the estimates are more accurate.”

White says it was not uncommon for her facility to receive three to five complaints each week from patients. Now it hardly receives any.

“It’s a much more valid statistical analysis,” she says. “Before, if a patient asked us how exactly we got his or her estimate, we didn’t have an answer. But that has changed.” ■

Questions? Comments? Ideas?

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Registration accuracy: How one facility turned to automated QA and dramatically reversed its error rates

by Paul Shorrosh, MSW, MBA

As a newly installed business office director at a 250-bed hospital with decentralized registration, I was astounded by the number of complaints I got each week from billing, collections, health information management, and even IT departments, all pointing to data quality errors that the patient registration department made.

It was, without a doubt, the number one internal complaint of the business office, which included patient financial services (PFS), billing, collections, and patient access departments.

After years of browbeating, the complaints had desensitized my access employees. My first inclination was to protect them, but at the same time, they needed to improve their billing accuracy rate. I needed a way to monitor and track accuracy, and somehow bridge the divide between front and back. Soon I began to envision a way for patient access employees to self-correct and learn from their mistakes.

I started by analyzing the complaints and ranking them by frequency and impact. I studied remit denials, billing system reports, and interviewed billing staff to identify the top five registration errors, then the top 10, until I understood what was going on.

The errors fell into three categories: financial, operational, and compliance. Financial errors, such as missing guarantor or subscriber information, invalid policy or group numbers, or missing authorizations, would stop or deny the claim.

Accident claims with missing occurrence codes were problematic, as were incomplete workers' compensation claims, secondary plans that were loaded as primary, and many others.

Operational errors cost us in terms of rework and returned mail due to incomplete names or addresses, invalid phone numbers, invalid punctuation, and

mismatched data elements, such as financial class and stay type, or certain admit codes that required a corresponding service code.

Compliance errors included patient safety issues, such as duplicate medical record numbers, as well as legal risks, such as minor guarantors, privacy notice errors, incomplete ER logs, and incomplete Medicare as Secondary Payer Questionnaires.

The more I looked, the longer my list became. Some errors, such as middle initials instead of names, seemed simple and even petty, but they caused confusion in choosing from the Master

Patient Index and often resulted in duplicate medical records—which creates a serious patient safety issue. Every error in patient access cost us dearly in legal risks, downstream rework, and, of course, payer denials.

In researching the problem further, I discovered that 70% of the data elements required to bill a UB-92 claim come from patient access. I learned from Zimmerman & Associates that registration error rates averaged 30% nationally, and were probably higher if the study had included the variety of error complaints that I was seeing.

Health Information Technology Magazine reported that as much as 80% of billing office staff time is dedicated to rework. What really caught my attention were estimates that 50%–90% of claim denials could be prevented by securing accurate patient information at the front door. Could it be that the “lowly” patient access employee could be the most valuable player in the entire revenue cycle?

I needed a way to monitor and track accuracy, and somehow bridge the divide between front and back. Soon I began to envision a way for patient access employees to self-correct and learn from their mistakes.

Like most of my counterparts, I understood fully the “garbage in, garbage out” theory. But every article I read and every workshop I attended recommended some form of manual quality review as the only solution, and we were already doing that, and doing it well—so well, in fact, that my patient access supervisors were spending three to four hours each day doing manual review and error reporting.

With 350 average registrations per day, they had time to review only about 30% of our accounts. Their primary tool was a static list of registrations from our patient accounting system, basically the hunt-and-peck method of identifying errors. They also reviewed the billing department’s marked-up face sheets and corrected errors so the claim could drop or, in some cases, rebill.

Then they keyed errors into spreadsheets in an attempt to organize the information and report it to each employee once per month. It was a valiant but ineffective effort and a poor use of valuable time and talent. No matter how well it was done, the error rate did not drop, and neither did the number of complaints, rework, or denials. We needed automation.

Back-end software tools for billing purposes were plentiful, but after a fruitless search for front-end solutions, I went to my patient accounting system vendor. After all, it was its registration system that allowed the errors to occur. But its response was basically “Problem—what problem?” It were not interested in developing a system solution for what it considered to be strictly a management problem.

Its recommendation was simply to “make the employees do it right.” This, of course, came from well-meaning folks who had never registered a patient or managed a patient access department.

But in their defense, it is hard to appreciate the complexity of patient registration if you’ve never actually done it. It looks like simple data entry, but look a little closer. In the past five years, I would estimate that the duties and complexity of the typical registration job have doubled.

Ten years ago, it resembled basic data entry with a smile. Now, aside from the 12–15 software applications

and Web sites that my staff had to master (compared to four for patient accounts staff), access employees typically are required to understand Medicare, Medicaid, managed care, and private insurance plans and regulations.

Today, patient registration staff members:

- Verify insurance and address information, eligibility, and physician orders
- Check for medical necessity
- Verify benefits, copays, and deductibles
- Interpret insurance coverage
- Price procedures
- Review prior balances
- Conduct basic financial counseling

Then there is the challenge of collecting copays and deductibles from sick patients at the point of service. This requires a finesse and style that come naturally to some and require scripting for most.

Some access employees also have the added duties of scheduling, preregistration, bed placement, and even early posting of procedures and charges. And that doesn’t even include the data-entry portion of the actual registration. Dare I mention the ever-looming requirements of HIPAA, Patient Rights, the Emergency Medical Treatment and Labor Act of 1986, and Fair Debt regulations, and The Joint Commission requirements? It’s no wonder that training and certification programs like the Certified Healthcare Access Associate have become so important.

These job challenges are compounded by high staff turnover, a constantly changing environment, an industry shift to decentralized registration models, the need to provide first-impression-level customer service, and the need for speed. Let’s face it: When you have 10 patients waiting to be registered, accuracy is sacrificed for speed, service, and collections. But accuracy is what gets you paid. What a dilemma for patient access managers and employees.

Ask others for help

We polled counterparts at other hospitals who also review random accounts manually.

> *continued on p. 6*

Registration accuracy

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The best programs had full-time staff dedicated to manual quality review, but even those programs were limited to random accounts, reviewer subjectivity, and inconsistencies. Were they reviewing for 10 types of errors or 50? How complete were the reports that they used to conduct reviews? And after finding errors, how do they record the information for statistical and training purposes? It was an information management problem begging for a solution, and it became apparent at my hospital that if I needed the solution, I would have to develop it.

After months of testing, we finally developed a model that automatically identified 15 common registration errors and reported them back to each patient access employee for self-correction. It was easy to use, and registrars immediately began self-correcting their errors prior to bill-drop.

Now that we could track error rates with relative ease, we watched them drop from 35% to 10% in the first six months. That year, we hit the lowest accounts receivable days in five years, and denials dropped by 20%. Our clean claim rate was higher, and the number of complaints from other departments trickled to almost nothing.


My patient access manager and supervisors recovered three to four hours per day previously spent on manual quality assurance (QA) to manage processes and train

employees more effectively. Patient access employees appreciated being able to learn about and correct their own errors before anyone downstream had a chance to complain. Soon our patient access staff members began competing to see who could have the lowest error rate in the department and who was registering the most patients per day.

After numerous requests from neighboring hospitals for an automated registration QA system, I redesigned the program for commercial use and protected it with copyrights and patent pending, and in only one year, it grew to 17 hospitals in seven states using the AccuReg[®], all through word-of-mouth referrals.

And about my old hospital . . . they tell me the error rate is now down to 5%. But even better than a 5% error rate is the knowledge that those few errors are corrected by patient access employees before they get to coding or billing. The only thing more rewarding is knowing that patient access employees can now become the most valuable players in the revenue cycle. ■

Editor's note: Shorrosh is the former business office director for Springhill Medical Center in Mobile, AL, and he currently serves as the president of Database Solutions, Inc. He can be reached at (866) 872-7498 or by e-mail at paul@accuregsoftware.com.

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This Month's
Form

Use this return on investment (ROI) calculator to determine how much it will cost your organization to conduct manual quality assurance (QA), relative to the depth of the review you are looking to perform.

Estimated ROI calculator for registration QA process

To customize the estimated ROI, enter values for your facility in the highlighted fields below:

Enter average registrations per year:

Enter average gross charges per account:

Enter the percentage of total accounts you wish to manually audit:

Enter the depth of the audit (number of error types to look for)

Estimate your current registration error rate:

100,000
\$ 3,000
25%
10
20%

FTE's needed to fill above requirements:

1.0

Notes

Avg. daily reg's M-F x 240 + avg daily reg's Sat/Sun x 96
One year average of gross charges - all accounts
1 FTE can review approximately 100 registrations per day or 24,000/year above based on depth of audit at 10 error types
**Zimmerman estimates national avg error rate at 30%

Denials prevention (write-offs due to denied claims)

Estimated error rate (already entered above):

Total erroneous accounts/year:

Enter estimated rate of financial (fatal) errors (ex; 35%):

Claims with fatal errors (at risk of denial):

Claims with fatal errors x average charge per claim:

Enter your average ratio of reimbursement to charges

Revenue at Risk:

Percent of errors PFS is correcting by timely filing limits:

Potential denials avoided from a registration QA process:

20%
20,000
10%
2,000
\$ 6,000,000
35%
\$ 2,100,000
90%
\$ 210,000

i.e., what percentage of your denials are registration-caused?

Enter your average reimbursement to charges rate

What percent of errors is PFS catching and fixing currently prior to timely filing limits?

Note: above calculator is for informational and estimation purposes only - above results are not guaranteed

For an electronic copy of this spreadsheet tool or for more information contact Database Solutions, Inc. (AccuReg Software) Toll Free: 866-872-7498
Or email to: info@accuregsoftware.com



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Download this entire form in the Patient Access Advisor section of www.accessresourcecenter.com.

Case study

Bottleneck breakdown: Resolve your discharge process first

People often point to long wait times in the ED as the source of bottlenecks in the patient access process. However, the problems do not always originate at the beginning of a hospital visit—instead, the end of the process, the discharge, is often to blame.

Lehigh Valley Hospital in Allentown, PA, learned this lesson during a three-year period.

The hospital was experiencing what **Terry Capuano, RN, MSN, MBA**, senior vice president of clinical services, calls “humble” admissions growth of 1%–2% in the early part of the decade.

“We were constrained by our capacity,” she says. “We had diversions in the [ED], holds in the [operating room], and we were turning away referral patients from other hospitals. Everything was bulging with demand.”

In 2001, the hospital administration made it a priority to solve this growing problem. It began to tackle the issue by taking a long look at its ED. “But no matter what we did for wait time or length of stay, it didn’t help,” Capuano says.

Although the ED felt like a logical starting point, leadership quickly learned it had to start at the end—the discharge process.

The hospital held a retreat with leadership from every department in the hospital. “There were several hundred people in a room,” she recalls.

Modeled after similar programs at Southwest Airlines, the group identified where it thought the problems began. Splitting up to work in groups of about 10, it came up with more than 1,000 ideas. After the daylong retreat, a core group culled through the ideas, looking for themes and priority areas.

For example, one problem that repeatedly came up was the lengthy period between a previous patient’s discharge and the time for a bed to become available. This issue became a priority, and the group looked for data.

“We broke it down to all the steps between discharge and having a clean bed ready for a new patient,” says Capuano.

Capuano formed teams to look at each problem. Between 2003 and 2005, the hospital took on 17 projects aimed at reducing bottlenecks (for a list of the projects, see “Try these 17 ideas to address bottlenecks” on p. 12). These projects could not have succeeded without the support of the organization’s patient access and case managers, who helped to break down barriers and resistance to change.

The initial projects, such as the discharge-to-clean-bed program, were the “low-hanging fruit.”

“We looked at what happens from when the physician writes the order and we say good-bye to the patient, to when the next patient gets that bed,” says Capuano.

One group focused on preparing the patient for discharge and another looked at how the patient got from the room to the door.

As a result of these early projects, Lehigh adopted the following changes to improve the discharge process and reduce bottlenecks:

➤ **Patient logistic system.** Before Lehigh Valley examined and revised its discharge process, volunteers or staff members from the unit were transporting patients. However, patients were often ready to go for a long time before someone came for them, Capuano says. This process is now a thing of the past. As a result of Lehigh’s initial projects, the organization created a patient logistics system.

A transporter is now called, so no one from the unit has to leave the floor to escort a patient. When that person reaches the patient’s room, he or she dials a number that goes directly to a bed-board system, which logs in an empty bed and automatically

generates a call to a cleaning SWAT team whose sole job is to clean beds for the next patient.

The SWAT team members dial the number when they arrive at a room, and again when they leave. The time it takes to clean various types of beds is monitored and compared to benchmarks.

When the bed is clean, staff members note it in the bed management system. Anyone in the organization can access that system—from the ED to the OR to units. “There was this myth that people were hiding beds. I don’t know how true it was, but even if it was, they can’t do it anymore,” says Capuano.

The time to prepare a bed for a new patient has been reduced from 210 to 60 minutes, and that figure has held steady for two years.

► **Improved ancillary services.** The hospital also sought to improve the availability of ancillary services so that physicians could get an early look at test results.

“We looked at staffing and hours of operation,” says Capuano. The organization also identified and prioritized tests that are needed for discharge.

► **Modified rounds.** When identifying obstacles to early discharge, the group noted that teaching rounds delayed the discharge process. Although physicians had traditionally made their rounds in the morning, the physicians were willing to try a different way.

“It had always been the sickest, the newest, the stable, and lastly, the discharges. But they were willing to rethink how the resident rounds were done and consider timing them later in the day so that discharge orders can be written first,” says Capuano.

► **Physician extenders.** Other physician groups were likewise willing to consider changes. The cardiothoracic surgery group hired a nurse practitioner to be on the units while they were in surgery. That extender helps get patients ready for discharge and handles tasks such as patient education. The group was able to shave 1.4 days off the length of stay in the past year and still maintains the best cardiac surgery outcomes in the state.

Help from case management

In addition to the larger system changes, the case management team also assisted in improving patient flow by focusing on a few process changes, says **Susan Lawrence, MS, CMAC**, administrator of the care continuum department.

Lawrence was instrumental in bringing the Extended Care Information Network (ECIN), an Internet-based discharge referral program, to Leigh Valley. The ECIN allows case managers to send an auto-

mated referral to dozens of nursing homes with a click of the mouse, says Lawrence.

“Our case managers used to call postacute providers on the phone to see if they had a bed, and if they did not, they’d move on to the next place,” says Lawrence. “Now [case managers] can send out certain demographic information on a patient, and if one provider cannot accept a patient, they can quickly send the same request to other agencies. They don’t have to recreate the request which saves lots of time and improves flow.”

The other significant change within the department was the creation of the complex case manager position . . . This position was developed to deal with patients with an extremely long length of stay—e.g., patients who require guardianship, insurance, or those with intense social issues, says Lawrence.

“When you have a unit case manager who has a list of 16–18 patients, the complex case keeps moving to the bottom of the list,” she says. “Now, a complex case manager can solely dedicate her time to moving these difficult patients along the continuum of care.” ■

“There was this myth that people were hiding beds. I don’t know how true it was, but even if it was, they can’t do it anymore.”
—Terry Capuano, RN, MSN, MBA

Postdischarge calls: A customer satisfier that builds loyalty

by June Stark, RN, BSN, MEd

Many experts argue that one of the most effective ways to enhance patient satisfaction during the discharge process is to implement postdischarge phone calls. Patient access or case management can make these calls to establish a rapport with the patients and ensure future business.

In the book *Patient Satisfaction and the Discharge Process: Evidence-Based Best Practices*, author and discharge expert Paul Alexander Clark says that if he could choose only one best practice measure to improve patient satisfaction scores, he would select postdischarge phone calls.

Calling every patient after his or her hospitalization helps build loyalty and is a market differentiator for hospitals, Clark says. He lists the following benefits of establishing a call program:

- ▶ Increased patient satisfaction
- ▶ Increased response rates to patient satisfaction surveys
- ▶ Better patient compliance with medication regimens, therapies, and appointments
- ▶ Improved medication safety
- ▶ Clearer understanding of your patient's perception of service
- ▶ Better clinical outcomes

North Shore Medical Center (NSMC) in Lynn, MA, recently had its case management department collaborate with the nursing department to launch a pilot postdischarge call program.

Following Clark's suggested guidelines and recommendations, NSMC established a modest goal in one surgical unit of contacting 100% of discharged patients within 24 to 48 hours after discharge during a six-week period.

Starting the program on only one floor meant the facility could roll out the program quickly, leaving enough time to analyze what was working and what was not.

NSMC drafted a postdischarge call policy and procedure document, which the call team used as a starting

point when contacting patients. (See "Sample discharge call program" on p. 11.)

Three RNs—two from the case management department and one from nursing administration—were assigned to make the calls and used a telephone script to guide the conversation with the patient.

During the first two weeks, the team focused on general questions and told patients that a hospital survey would soon follow. Once the team became more comfortable and developed their telephone skills, it asked more detailed questions concerning the quality of the discharge.

The first part of the script contains introductory questions, such as the following example:

Hello Mr./Mrs./Ms., this is _____, from the case management department at North Shore Medical Center. I am calling to see how you are doing since your discharge. Do you have a few minutes to speak with me? We want to ensure that our patients are receiving very good patient care. How was your stay? Is there anything else that we could have done to improve your stay?

The script continues with detailed questions about postdischarge care needs, such as medication administration or pain management. Patients are also told that they will receive a patient satisfaction survey and that their feedback is important and appreciated.

In consideration of HIPAA guidelines, if patients are not home, the team does not leave a message. If staff members cannot reach a patient, they make a second attempt. Any patient complaints or further discharge needs are directed to the appropriate individual for further investigation, support, and resolution. A data collection tool also tracks the outcome of each call. Staff members document in the patient's medical record any new patient intervention provided as a result of the call, and label it as a "postdischarge call intervention." ■

Editor's note: Stark is the director of case management at Salem (MA) Hospital and North Shore Medical Center, in Lynn, MA.

This Month's
Form

Sample postdischarge call program

Purpose:

Postdischarge calls are an important component of a service-oriented culture. They help our hospital in the following ways:

- Express concern for the smooth transition from hospital to home
- Leave a lasting impression of North Shore Medical Center (NSMC)
- Communicate a patient's perception of service/gather patient feedback
- Clarify discharge instructions through referral to a case manager
- Identify areas for service recovery
- Improve clinical outcomes

Procedure:

- All patients discharged to home from West-2 will receive a postdischarge call (PDC).
- A member of the NSMC case management department or nursing administration will make the PDC.
- A daily report designed to meet the purposes of the PDC program will identify the patient. The administrative assistant will e-mail the calls, which need to be made on weekdays. Weekend discharge calls will be picked up on Monday.
- Patients will be called 24–48 hours after discharge.
- Two attempts will be made to reach each patient. Do not leave messages.
- Upon reaching the patient, follow and complete the PDC script.
- The goal is for each call to last approximately three minutes. Calls with issues and/or concerns will last longer, approximately five minutes.
- Delegate concerns/issues to the appropriate and accountable individual at NSMC.
- Place the completed discharge phone call form in the progress notes of the patient's permanent record.
- At the end of each month, a report communicating the results of PDC's activities/outcomes will be generated, including:
 - Number of PDC calls/number of attempts
 - Who made PDC calls
 - Number of satisfied customers versus dissatisfied
 - Number and type of issues and concerns
 - Issues/concerns: delegated to whom
 - Follow-up reports about patient complaints
- The PDC activities/outcome report will be presented monthly to hospital customer service committee.
- We will conduct a recognition program for physicians/health care providers/employees identified positively by patients.

Authorized signatures

Director

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➤ Download this entire form in the **Patient Access Advisor** section of www.accessresourcecenter.com.

Try these 17 ideas to address bottlenecks

Following is a list of projects that Lehigh Valley Hospital in Allentown, PA, initiated to resolve bottlenecks. If your facility is experiencing similar problems, you may want to try implementing them.

1. Discharge process: Focused on physician communication and the nursing/case management staff process of patient discharge

2. Transport mechanics for discharge: Designed centralized patient transport process for patient discharge to reduce delays in discharge process and bed turnaround times

3. External transport (centralized ambulance): Designed a centralized ambulance transport function to expedite, coordinate, and prioritize movement of patients to other care facilities, and to reduce the number of extraneous phone calls required by case managers

4. Discharge bed turnaround time: Redesigned the reporting and process of cleaning dirty beds and the reporting of clean beds to reduce delays in bed turnaround times and availability

5. Bed tracking software: Designed a vendor-supported technology application to complement and accelerate the discharge bed turnaround process through real-time bed status reporting

6. Intra-hospital transfers: Redesigned the process for transfer of patients within the hospital, including the design of the patient flow coordinator role

7. Short-stay hospital implementation: Implemented a short-stay hospital for one- and two-day-stay ambulatory surgery, off-loading select surgical volume from the tertiary campus

8. Find-a-bed implementation: Without physically expanding, created additional capacity of 70 licensed beds

by converting storage closets, offices, lounges, and waiting rooms into patient rooms

9. Expanded express admissions unit feasibility:

Determined the feasibility of expanding the express admissions unit model to seven beds to expedite direct admission and off-loading of ED volume

10. Observation unit feasibility: Determined the feasibility of the operation of a universal unit for observation patients

11. Ancillary services feasibility: Determined feasibility of expanding ancillary services hours to facilitate patient discharge

12. Patient logistics implementation: Created a new function in patient logistics by stitching together six sub-projects and implementing an integrated plan

13. "Pull" system: Designed and implemented an automatic pull system for patient admissions and transfers

14. Smoothing feasibility: Conducted a feasibility study to identify opportunities to smooth the flow of patients in and out of surgical and cardiac catheterization areas

15. Timely discharge: Tested discharge by appointment, distributed boxed lunches, and implemented a discharge time accountability reporting system for physicians to increase the percentage of patients with timely discharges

16. Shorten outpatient stays: Designed and implemented a collaborative rounding program and long-stay SWAT meetings, and recommended additional beds on the subacute care unit and transitional skilled unit

17. ED length-of-stay reduction: Designed and implemented ED process improvements to reduce ED length of stay