Still defining its role

Access Center Pushes Hospital Doors Wider

By Tyler Smith

In a small room tucked into the first floor of the Anschutz Inpatient Pavilion, four individuals sit at their stations, computers and phones in front of them, large screens filled with colored circles and boxes overhead. The soft voices of the room’s occupants give little hint of the central role they play in the bustling hospital environment just outside their doors.

Welcome to the Access Center, the figurative front door to University of Colorado Hospital for many providers around the metro Denver area and beyond. The 24/7 operation plays a key role in managing capacity, establishing strong relationships with referring providers, and ensuring the hospital complies with regulatory requirements.

It’s also an entity in transition. Critical care RNs were recently added to an Access Center that historically was staffed by clerical access center specialists. A lack of trust in the Access Center – created by transfers sometimes delayed and lost – led some physicians to create “back channel” phone lines with referring providers seeking to admit patients, a complication for a hospital that routinely runs at or above capacity.

The coordination kinks contributed to a persistent perception among some community providers that UCH was a “black hole” – an institution more akin to a Fortress of Solitude than one with a welcome mat.

In response, hospital leadership has instituted a number of changes to strengthen the Access Center. The aims: reduce physician response time to Access Center calls to five minutes or less; the time of the call to patient acceptance to 30 minutes or less; and the percentage of lost transfers to 3 percent or less.

Hitting those goals is a work in progress, but the Access Center is moving in the right direction, said Rob Leeret, director of Emergency and Trauma Services and Capacity Management for the hospital.

“We’ve made incredible progress,” he said. “We’re continuing to work on getting the commitment from attending on-call physicians that this is among our highest priorities.”

Makeover. Leeret is part of the change. He now directs the Access Center, which was formerly solely under Finance, reporting to both Finance and hospital operations. Larissa Thorniley, RN, manages the center, which is now staffed with experienced nurses trained in critical care. The Access Center documents every call electronically with everything from patient demographic information to payer source to descriptions of medical issues. It also records every call and conducts random audits to ensure providers and Access Center staff conduct themselves professionally.

The Access Center is also now tied directly into the hospital’s activity. Staff watch a TeleTracking board, which shows the status of beds on each unit. Rather than handing off patient admission...
requests to hospital managers, as they used to, Access Center staff make bed assignments in real time, follow up with referring providers, and help organize transportation if there will be a delay because the hospital is full. Another large board shows hospital capacity up to the minute, helping staff to make informed judgments on requests to admit patients.

On the provider side, physicians have worked with Thorniley to create protocols to immediately accept trauma, burn, stroke, heart attack, and neurosurgical emergencies. “Umbrella acceptance” policies have also helped to streamline care. For example, the Trauma and Acute Care Surgery (TACS) service now accepts patients with multiple issues on behalf of Orthopedics and other services, eliminating potentially lengthy delays.

“The Trauma Service knows the scope of practice for patients with multiple injuries and can accept the patient with the understanding that it involves other specialties,” said Robert McIntyre, MD, director of trauma and emergency surgery. “We can get the patient transferred immediately and save steps.”

The revamped Access Center also collects information on all patients denied admission, in part to protect against violations of EMTALA, the federal law that requires all Medicare-participating hospitals that offer emergency services to provide medical screening examinations to individuals with emergency medical conditions and provide stabilizing treatment, regardless of their ability to pay.

A transfer denial at UCH that was ruled an EMTALA violation in Jan. 2013 helped spur the decision to staff the Access Center with clinical providers better equipped to evaluate the hospital’s regulatory responsibilities and work toward codifying the transfer acceptance process. Thorniley reviews all transfer denials for potential issues and escalates them for further review, if necessary. The hospital’s EMTALA Committee reviews all denials on a monthly basis for additional evaluation and performance improvement.

Changing the image. The Access Center changes have helped to rehabilitate the hospital’s image with community providers, Leeret said. “The nursing staff have been critical to helping us think through the service referring physicians need and answering questions to determine the level of a patient’s need,” he noted.

But he conceded that challenges remain, not only in changing the view of community physicians, but also the perceptions of the hospital’s own providers. For example, some physicians frustrated with the inability of the hospital to quickly find beds for patients long ago resorted to back-channel methods: private cell phone numbers or special lines to their units.

Changing those physicians’ habits will take time, Leeret acknowledged. “We have to build trust with them,” he said. But bypassing the Access Center creates problems for the hospital, he noted, among them a lack of documentation about referring and receiving physicians as well as treatment plans.

Using the Access Center can also help streamline care for patients who need to be transferred from other institutions, Thorniley added. “We can keep nurses at the bedside instead of tracking down physicians on the unit to come to the phone,” she said.

The back channels persist, as was evidenced on a recent morning in the Access Center. Chad Kile, a non-clinical Access Center specialist, took a call from a provider seeking a bed for a direct admit clinic patient. Kile quickly collected information, including the patient’s name, where she was coming from, and the clinical issue. He found the physician on call, looked at the TeleTracking board and made a bed request to the Access Center placement nurse to admit the patient.

After finishing the work, he noted that the referring physician had already been told he could admit the patient. On this particular day, capacity wasn’t an issue. Had it been, Kile would have had a more difficult conversation to manage.
Identity issues. Richard Zane, MD, chair of the Department of Emergency Medicine at the CU School of Medicine, said the Access Center must deliver "exceptional bidirectional service" to both referring and accepting physicians if it is to decrease reliance on back channels.

“The relationships that specialists have developed with other providers are incredibly important – and universally good,” he said. “Both referring and accepting physicians have to have confidence that the Access Center can provide the level of service to not only preserve but grow and enhance those relationships.”

Ideally, Zane said, a physician at UCH receiving a call from a referring provider would have enough confidence in the Access Center to defer all of the administrative tasks and admission details to its staff.

Zane, who built and ran the access center at Partners HealthCare in Boston before joining CU in 2012, said a successful center is more than “logistical components.” Rather, he said, it’s a reflection of the institution itself.

“We want to be seen as the only tertiary care center in the region,” he said. The best-performing access centers, he maintained, accept all difficult cases, monitor them and look for issues as they arise.

“We need unity of vision about what we provide as a tertiary referral center,” Leeret said. “The highest functioning centers just say yes” to transfers. He added that data show such a policy produces increases in business with a minimal erosion of payer mix. “Other providers are calling us because they have patients who are beyond their capability to care for,” he said.

McIntyre cautioned, however, that the hospital must carefully evaluate requests for transfer to ensure that referring institutions aren’t simply passing on patients they could care for but don’t want to because of poor insurance coverage.

“We are capable of accepting everything,” he said, “but we have capacity issues. We need to protect our resources and ensure that when we deliver care to the uninsured or the underinsured, it is for those patients who truly need our services.” That means, he added, not using the hospital’s financial resources to care for routine cases that can be handled in the community.

Front lines. A successful Access Center also needs infrastructure that matches the goals of the institution, said Tatyana Popkova, director of UCH’s cross-enterprise surgical program. Popkova was involved in building the access center at Johns Hopkins in Baltimore, a Level I trauma center with heavy transfer and emergency volume, including many patients with gunshot and stab wounds.

“You always build today for where you want to be in five years,” Popkova said. That means, for example, creating an Access Center staff with the expertise to recognize differences “big and subtle” in patients in key service lines, such as neurology or cardiology, the hospital has identified as part of its strategic plan, she added.

Both Popkova and Zane advocate linking the Access Center to a core group of physicians – “customer service- and referral-centric,” in Zane’s words – responsible for ensuring that patients who need the hospital’s specialized services are admitted smoothly and efficiently.

“The ideal is to create a schedule of dedicated people who are expected to get back to referring physicians instantaneously,” Popkova said. That group must also commit to addressing and finding solutions for capacity problems, she added.
Ultimately, lost transfers mean lost business for the hospital, Leeret said, and the reasons for them are sometimes still hard to pin down. Organizing the Access Center and strengthening its relationships with physicians could help to solve the problem, he said.

“We need the chairs of the departments to hear that message,” he said, “and understand what the Access Center could be.”