

MEDICAL CALL CENTER NEWS

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Learning the Lingo

By Claudia Volkman

The term “acronym” was coined back in 1943, and today acronyms are used most often to abbreviate the names of organizations and long or frequently referenced terms. Both government and business commonly employ the use of acronyms, and the healthcare and medical call center industries have their own specific acronyms. As a new medical call center agent, this can be challenging and somewhat confusing – almost like learning a foreign language. Since new acronyms are being created all the time, even seasoned agents can be thrown off at times.

These acronyms show up wherever you go in the healthcare and medical call center field. From Web sites and articles to conferences and meetings, developing a familiarity with industry lingo is an important aspect of an agent’s knowledge base. Below is a handy list you can refer to:

Medical Call Centers

AHL - Audio Health Library
CBT - Computer Based Training
CM - Care Management
CRM - Customer Relationship Management
DM - Disease Management
EMR / EHR - Electronic Medical Record / Electronic Health Record
MSR - Medical Service Representative
NAL - Nurse Advice Line
PRM - Patient Relationship Management
RTS - Rapid Triage Screening
RN - Registered Nurse
TED - Triage Encounter Document
TDD - Telecommunications Device for the Deaf
WFM - Workforce Management

Call Center Quality

HEDIS - Healthcare Effectiveness Data and Information Set
HIPAA - Health Information Portability Act
JCAHO - Joint Commission on Accreditation of Healthcare Organizations
NCQA - The National Committee for Quality Assurance
PHI - Protected Health Information

QA - Quality Assurance
QC - Quality Control
URAC - Utilization Review Accreditation Commission
VoIP - Voice over Internet Protocol

Call Center Metrics

ABN - Average Time to Abandonment
ASA - Average Speed of Answer
ATB - All Trunks Busy
CHT - Call Handle Time

Do you have other acronyms we can add? Feel free to share them with MCCN (Medical Call Center News) by emailing them to peter@medicalcallcenternews.com.

Ten Hospitals Win National Charitable Award

Community programs as diverse as a free health clinic to parenting programs and an infant mortality service were selected as winners at the first annual national Hospital Charitable Service Awards presented by Jackson Healthcare. At a dinner highlighted with a speech by former House Speaker Newt Gingrich, founder of the Center for Health Transformation, the ten charitable programs were awarded \$10,000 each for their good works in their communities. Across the country, 110 hospitals submitted nominations for the award that sought to recognize more than just traditional charitable care.

“These ten winners are just jewels in their communities,” said Charles Evans, FACHE, chairman of the Awards program. “Every one of the nominees is doing terrific charitable work in its community, but these ten did amazing things for their constituents.” The 2011 winners of the Hospital Charitable Service Awards are:

- Cabell Huntington Hospital (Huntington, WV): *Healthy Tri State* program is an education program aimed at combating obesity.
 - William Beaumont Hospitals (Royal Oak, MI): *Parenting Program* trains volunteers to prevent child abuse.
 - St. John Providence Health System (Highland Park, MI): *Infant Mortality Program* effectively works to combat infant mortality.
 - Yakima Valley Memorial Hospital (Yakima, WA): *Children’s Village* works with special needs children to offer coordinated care.
 - Mercy St. Vincent Medical Center (Toledo, OH): *CareNet Program* coordinates physicians and volunteers to offer complimentary, preventative healthcare to the uninsured.
 - Sentara Obici Hospital (Suffolk, VA): *Community Health Outreach Program* helps patients at high risk for repeat issues with heart disease and diabetes.
 - Bon Secours St. Francis Health System (Greenville, SC): *The Health Community Initiative* works to maximize health in the minority community.
 - Cape Regional Medical Center (Cape May Court House, NJ): The *Parish Nurse Program* recruits volunteer nurses to work at more than fifty church parishes.
 - Mercy and Memorial Hospitals (Bakersfield, CA): *Community Wellness Program* primarily targets the poor and uninsured.
 - Northeast Georgia Medical Center (Gainesville, GA): The *Health Access Initiative and Good News Clinics* host volunteer medical personnel who treat the working poor and uninsured with both medical and dental care.
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Elderly Patients with Dementia and Delirium Rarely Understand ER Discharge Instructions

The first study to investigate the effects of delirium and dementia on emergency patients' ability to accurately explain their symptoms and to understand their discharge instructions finds a significant "invisible hazard" for both patients and emergency department healthcare providers. The results of the study are published in the *Annals of Emergency Medicine* ("The Effect of Cognitive Impairment on the Accuracy of the Presenting Complaint and Discharge Instruction Comprehension in Older Emergency Department Patients").

"We found that elderly patients with cognitive impairment could not accurately explain why they were in the emergency department," said lead study author Jin H. Han, MD, MSc, of Vanderbilt University in Nashville, Tennessee. "Furthermore, those patients with cognitive impairment had decreased comprehension of their discharge instructions, which may negatively impact patient safety. Emergency physicians miss delirium and dementia in the majority of cases because emergency patients are not routinely screened for them. Our study suggests that screening for these forms of cognitive impairment in the emergency department is warranted."

Delirium and dementia occur in 25 percent of older emergency patients. Elderly patients account for 17 million visits to emergency departments annually, a number that is expected to balloon as the U.S. population ages. By 2030, one-fifth of Americans will be sixty-five or older. "Elderly emergency patients with cognitive impairment are at higher risk for miscommunicating their needs and misunderstanding the discharge care plan," said Dr. Han.

Acetaminophen Can Increase Blood Pressure

Acetaminophen (Tylenol[®], generic) has long been promoted as a safer alternative to aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen (Advil[®], generic) for people with cardiovascular disease who need relief from aches and pains. A small but important Swiss trial warns that it may not be, reports the February 2011 issue of the *Harvard Heart Letter*. These new results don't mean that you should ditch acetaminophen if it helps you, but they do suggest you should give it the caution that it – and every medication – deserves.

The Swiss researchers asked thirty-three men and women with coronary artery disease – including angina (chest pain with exercise or stress), previous bypass surgery or angioplasty, or a diagnosis of cholesterol-clogged arteries – to take either 1,000 milligrams of acetaminophen or a placebo three times a day for two weeks. The amount of acetaminophen used in the study is a standard daily dose for pain. Average blood pressure rose when the participants took acetaminophen, but stayed steady when they took the placebo.

Acetaminophen is easier on the stomach than aspirin and other NSAIDs. Because it is so widely used and perceived as safe, people tend to take it without thinking, but it has side effects, too. In fact, acetaminophen is a leading cause of liver failure and transplantation in the United States. For those with some form of cardiovascular disease, it makes sense to take acetaminophen rather than an NSAID for a fever, headache, pulled muscle, or other occasional problem. But for relief every day for pain from osteoarthritis or rheumatoid arthritis, acetaminophen may not be the best option – it doesn't work that well against inflammatory pain, and it can elevate blood pressure.

Robard Corporation Announces Three Health and Wellness Initiatives

The health and wellness organization, Robard Corporation, announced three new wellness initiatives directed at dieters, its own employees, and weight loss centers. The first, the Dieter Referral Program, aims to make the company's programs and products accessible to all potential dieters. To achieve this, Robard is offering to pay dieters to lose weight. Potential dieters are encouraged to go online and visit www.Robard.com/ReferralProgram to request a packet of materials and program details.

In addition to the Dieter Referral Program, Robard is helping its own employees with a new corporate "biggest loser" program and partnership with the "Pound for Pound Challenge." For every pound Robard employees pledge to lose, eleven cents will be donated to Feeding America – enough to secure one pound of groceries for the South Jersey Food Bank. The goal is to help employees lead healthier lives while also lending support to those in need.

Finally, since one in ten U.S. adults now has diabetes (CDC, October 2010), Robard, in conjunction with a highly regarded endocrinologist, Dr. Christopher Case, MD, of the Jefferson City Medical Group, has developed the Diabetes Medical Protocol to address this. It is the first nationally available comprehensive Very Low Calorie Diet (VLCD) to offer educational materials and medical guidelines specifically for patients with type 2 diabetes. The Diabetes Medical Protocol helps overweight and obese patients with type 2 diabetes lose and control their weight, normalize blood glucose levels, and reduce plasma lipid levels and blood pressure.

Health Systems Underestimate EMR Costs

By Nicole Lewis, InformationWeek

According to a study by Accenture, most health delivery organizations underestimate the time and costs associated with implementing advanced electronic medical record (EMR) functions, including clinical order entry, nursing and physician documentation, clinical decision support, and bar-coding medications.

Released last week, the study, "Secrets of Success on the EMR Journey to Meaningful Use: Leading Hospital CIOs Reveal Key Lessons Learned," also found that hospitals experience significant spikes in operating costs during the time that they install EMR systems.

Accenture said it interviewed fifteen CIOs who work at healthcare delivery organizations that are advanced in their EMR implementations. They used quantitative benchmarking to identify the following six key insights that can help health delivery organizations successfully adopt their EMR technology.

1. EMR planning and implementation must be a strategic initiative, not an IT initiative.
2. It takes longer and costs more than most anticipate.
3. IT operating costs will spike.
4. There is a significant shortage of qualified health IT professionals to implement and support EMR.
5. Supporting EMR means thinking differently about capability and operating model needs.
6. Creating a culture for adoption is essential.

http://www.informationweek.com/news/healthcare/EMR/showArticle.jhtml?articleID=229100222&cid=nl_IW_healthcare_2011-01-26_html

The Great Tonsil Dilemma

Without fanfare, hundreds of thousands of children surrender their tonsils to a surgeon's scalpel each year, usually to alleviate recurring infections and obstructive sleep problems. Most of the time, the snipped tonsils are sent to a pathologist, who looks for evidence of more serious medical problems, like unsuspected cancer.

But this common practice may not be cost-effective, because those additional examinations rarely lead to the discovery of hidden disease, a new University of Michigan Health System analysis shows.

The approximately \$35 million spent nationwide on such examinations each year might have more impact if spent elsewhere in the healthcare system, says the study's senior author, Marc C. Thorne, MD, MPH, assistant professor of otolaryngology at the U-M Medical School.

"The question is: How do we make rational use of our healthcare dollars?" asks Thorne. "It's a matter both of economics and of societal values."

Read more at: http://www.uofmhealth.org/News/tonsil_otolaryngology_0208

Most People Unwilling to Use Automatic External Defibrillators

A Dutch study published online in *Annals of Emergency Medicine* reports that less than half (47 percent) of people in a public place with access to an automatic external defibrillator (AED) would be willing to use it, with more than half (53 percent) unable even to recognize one ("Public Access Defibrillation: Time to Access the Public").

"An AED is only beneficial if a bystander is willing to use it when someone is in cardiac arrest," said lead study author Patrick Schober, MD, PhD, of V.U. University Medical Center in Amsterdam, the Netherlands. "AEDs are increasingly available in public places, such as the train station where we conducted our survey. However, in our study, only 28 percent of participants correctly identified the AED, knew its purpose, and expressed a willingness to use it."

Just over one-third (34 percent) of the participants stated that anyone is allowed to use an AED, with nearly half (49 percent) believing only trained personnel may use it. The most frequently mentioned reason given for not using an AED was not knowing how it works (69 percent), following by fear of harming the victim (14 percent). Only 6 percent of study participants spontaneously mentioned AEDs in response to a question about what should be done as quickly as possible for someone suspected of being in cardiac arrest.

Sudden cardiac arrest is a leading cause of mortality in North America and Europe. The odds of survival decline by 7 to 10 percent per minute of delay in defibrillation. AED application by bystanders saves only 1.4 lives per one million people in North America.

"AEDs are actually very easy to use, but it is obvious that the public has not gotten that message," said Dr. Schober. "Only a minority of individuals demonstrated both knowledge and willingness to operate an AED. Wide-scale public information campaigns are an important next step to exploit the lifesaving potential of public AEDs."