

# Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END

## Not-for-profit group exploring technological tool to fix

Fact: Many people who do not have a primary care physician (PCP) use hospital EDs for nonemergent care.

Fact: Many people linked to a PCP use EDs for non-emergent care because they believe that their physicians are inaccessible or that their local hospital's quality of care and technology are superior.

Fact: The widespread use of EDs for any reason other than emergency care—and its direct effect on wait times and quality of care—is a significant clinical, financial, and customer service issue for providers.

Approximately 18 months ago, the St. Louis Integrated Health Network (IHN), a partnership of local providers and government agencies, identified this problem as one for which the solution would require more than just an individual hospital process reevaluation and restructuring.

Uniting competitive providers in St. Louis for the com-

mon goal of improving the healthcare system as a whole is the ultimate goal of the Primary Care Home Initiative.

In addition, the IHN hopes that new referral processes and an interconnected health information exchange or Network Master Patient Index (NMPI) will be the formula that links patients to quality PCPs for appropriate preventive care.

“The use of our EDs for issues like sore throats and other nonemergencies was an increasing problem,” says **Brooke Sehy**, the interim executive director of IHN and the chief of staff at the

**“The use of our EDs for issues like sore throats and other nonemergencies was an increasing problem.”**

—Brooke Sehy

St. Louis Regional Health Commission. “We felt this was a problem in ensuring our patients good continuity of care. It’s well known that a better doctor-patient relationship produces better outcomes.”

Not to mention that the widespread overuse of EDs directly affects the cost of healthcare. In its initial research, IHN found that the average price of an ED visit in St. Louis was \$560, as opposed to \$121 for a PCP visit. IHN also found that 37% of ED visits in St. Louis were for nonemergencies.

“Those costs are borne by everyone, not just the people who visit the ED,” Sehy says. “So if we can find a more efficient and effective way to provide care, it can result in improved care and savings that will be passed along to businesses, insurance payers, hospitals, and patients.”

The potential cost savings and improvements in care are what drive providers to team together. “All of the providers are feeling the pressure in their EDs,” says Sehy. “We were able to come together and make great progress.”

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## ER volume

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### The first step

In early 2005, IHN gathered 40 representatives with various clinical, information technology (IT), and operations backgrounds from 16 area providers with the goal of developing a better PCP referral process for patients. The 16 organizations included primary care, specialty care, and hospital ED providers.

In the first phase, the group set out to

- ▶ define project goals
- ▶ evaluate organizational readiness to participate in health information exchange, primary care home management, and referral process redesign

- ▶ gain an understanding of the participating organizations' IT application architecture, data architecture, and the degree to which these architectures could support a standard data-set definition of an NMPI
- ▶ evaluate the capabilities of the organizations' IT function in terms of their ability to support the future solution
- ▶ develop a high-level implementation plan

### Take two

IHN completed the first phase late in 2005. In phase two, it set out to design the NMPI technology solution, select vendors, and develop new referral processes in partnership with IBM Consulting Services.

Sehy estimates that implementation of the health information exchange and new processes will come with a price tag of \$4 mil-

**“We’re committed to building a sustainable funding model and a system that works effectively for our patients and providers.”**

—Brooke Sehy

lion–\$5 million, which doesn't include operating costs. So far, local providers have contributed \$625,000 toward the project.

In addition to the design, IBM is working with IHN to develop a financial benefits and cost analysis tool for providers.

“We’re committed to building a sustainable funding model and a system that works effectively for our patients and providers,” says Sehy.

The other goals of the second phase are

- ▶ process analysis and design
- ▶ technical design and system selection
- ▶ economic modeling and value proposition development
- ▶ governance set up
- ▶ project charter development
- ▶ clinical adoption

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## FQHCs: Providing hospitals lessons of patient convenience

More than 3,000 national, federally qualified health centers' (FQHC) sole purpose is to cater to their communities' needy and medically underserved population—the same people who feel rebuffed by the traditional health-care system.

There are patient management lessons hospitals can learn from many of the new FQHCs, including Squirrel Hill Health Center (SHHC) in Pittsburgh, such as how to consistently put the customer's needs first and, ultimately, realize the positives that can result from a partnership—officially or unofficially—with an area FQHC.

"If hospitals haven't forged a relationship with area community health centers, they should," says **Susan Friedberg Kalson**, SHHC's CEO.

SHHC held its grand opening October 29, 2006, but its physicians began seeing patients in June 2006. Billed as a center that offers comprehensive and preventive health-care for everyone—not just the uninsured—SHHC helps unclutter area EDs by taking those patients who use hospitals for nonemergent care.

Although this practice translates into fewer patients through your doors, it also means happier patients at the time of service because of the more efficient care you can offer to those who truly need it. From an administrative standpoint, it also means less volume, fewer clerical mistakes, fewer denials, and, ultimately, more revenue.

### An idea comes to fruition

Three years ago, the Jewish Healthcare Foundation (JHF) determined that there was an unmet need for an FQHC in a particular area of Pittsburgh where the uninsured population didn't have enough affordable health-care options. "[The foundation] did all the background work and put the time and effort and staff hours into researching and writing a proposal [for the federal grant]," Kalson says.

The federal government looks at census data and poverty statistics and determines whether there is a real need in a specific community. In February 2006, the gov-

ernment approved the JHF's third attempt at a proposal.

Upon hearing the decision, the JHF had 120 days to help the center get off the ground. It had already organized a board of directors. By law, 51% of the board must be consumers. The JHF also had to locate space and recruit staff (e.g., a medical director, practice manager, physician, and CEO).

The next phase of the operation was consolidating the entire staff and purchasing equipment (e.g., computers.) To remain in line with the government's movement toward electronic health records, SHHC has state-of-the-art technology. "It allows us to track patients quickly and submit necessary information to the government quickly," Kalson says.

### Customer conveniences

The government grant comes with a theoretical blueprint, which includes the placement of

- ▶ social workers
- ▶ financial counselors
- ▶ behavioral specialists
- ▶ case managers

The government also urges the creation of pharmacy and dental services. SHHC will open its pharmacy in 2007 and has future plans for a dental practice.

"[The government's] priority is that the patients get all of these services under the same roof," Kalson says. "We can then track the patients' care more easily. We know if you've had a refill, and we can follow up."

Hospitals can also take a page out of SHHC's customer considerations. For example, signs are printed in several languages to accommodate the different cultural backgrounds in the community. Additionally, SHHC employs physicians who speak Russian, Spanish, Hebrew, and American Sign Language.

SHHC also trains its employees to welcome people from different backgrounds. The center pays close atten-

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## FQHCs

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tion to who it hires and uses guidance from the Welcome Center for Immigrants & Internationals in Pittsburgh, an organization that helps immigrants adjust to their new surroundings.

Another patient convenience is the use of smaller adjustable-height exam room tables, which are particularly helpful for patients transferring from wheelchairs, and for smaller patients who might otherwise have difficulty propping themselves up.

SHHC is also working hard to improve throughput and decrease wait times. To that end, most exam rooms are fully equipped so patients aren't shuffled back and forth between rooms.

Another patient convenience is the return of house calls. "Our medical director really sees that as a need," Kalson says. If her patients are sick and unable to come in, she will go to them.

### It's time to open up

SHHC knows that to attract patients it has to rethink its hours of operation. It's difficult for many patients to make appointments for care during traditional business hours.

SHHC is open one night per week and plans to offer evening and Sunday hours, as well. "Staffing is a challenge, because we want to be up and running, but we need to be fully staffed," Kalson says. "Several of our physicians are part-time and want to be working that way."

The physicians on staff are committed to this model of community care, she adds. Many come from the hospital setting and are tuned in to how frustrating it is when care is hindered by factors such as insurance.

"So they are very excited to work in a hands-on model," Kalson says.

### Tearing down the insurance walls

An exciting part of working at SHHC, says Kalson, is that it doesn't really distinguish between the uninsured and insured populations, although she guesses that as many as 30% of SHHC's patients are uninsured.

"Everyone's welcome here," she says. "We are attentive to the needs of everyone."

Providing an affordable, convenient option for people who once didn't have one is rewarding. SHHC can take on patients whom another hospital would prefer not to.

"I think it's what gets us up in the morning," says Kalson. "We all know [being uninsured is] a huge issue in this country, and the latest statistics show it's an increasing issue.

But it's also very gratifying to know that you can touch people's lives, that they can come in, and you can connect

them to the care that they need."

Kalson believes hospitals should attempt to team up with FQHCs, not only to relieve the stress on their EDs, but also to strive to create a healthier population.

"We're a piece in the link that provides complete coverage of care," she says. "We all have the goal of keeping patients healthier." ■

**"I think it's what gets us up in the morning. We all know [being uninsured is] a huge issue in this country."**

—Susan Friedberg Kalson

## Upcoming events

**January 31—Operationalizing the UB-04: Tested strategies to reduce risk and maintain compliance**

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*For more information, visit [www.hcmarketplace.com](http://www.hcmarketplace.com) and click on the "Ambulatory Surgery" tab or call our Customer Service Department at 800/650-6787.*



## Revised DRGs: Prepare for impact on service lines

by Preston Gee

We are on the eve of a seismic change in revenue reimbursement for hospitals with the reconfiguration of DRGs as recalibrated by CMS in 2006.

The new configuration is a modification to the inpatient prospective payment system (IPPS). Surprisingly, other than running the numbers and issuing a cursory first-pass analysis, many hospitals and health systems are not undergoing or undertaking the kind of in-depth review and on-deck evaluation that the IPPS should merit.

However, healthcare leaders need to recognize that much of their world is about to change dramatically—prompting a veritable paradigm shift in long-range planning considerations.

### The decline of the core four?

One example of this significant change will be the effect on the four high-focus service lines that typically constitute the bulk of operating revenues and contribution margins.

It has been widely held by hospitals for the past few years that the “Pareto Group” that commands management’s attention and prompts intense competition includes the cardiovascular, orthopedic, neurosciences, and general surgery service lines.

For most mid- to large-scale hospitals, these four areas typically account for 60%–75% of the critical financial and market share metrics that hospital executives track. That managerial maxim may be about to change.

For example, one large system in Texas—which just calculated the effect of the IPPS changes on its reimbursement—estimated that the cardiovascular service line will realize a 30% reduction in its total revenue.

Other across-the-board reimbursement calculations for cardiology range from The Advisory Board’s estimate of a 9% overall reduction to a leading systems projection of 40%–50% for certain specialty hospitals.

Although the other key lines—orthopedics, neurosurgery, and general surgery—will not be hit as hard, they will no doubt feel the pain of the surgical strikes.

All of this change carries with it major implications because hospitals for the past five to 10 years have expended disproportionate capital and management time on these service lines.

With their cachet and contribution now expected to diminish some—although, admittedly, they will still be major players—hospitals’ emphasis may need to turn to other areas of the portfolio that healthcare executives have long considered second-tier services or third-rate margin contributors.

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## Revised DRGs

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### Margin makeover

One of these areas is the entire milieu of medical diagnoses. Partly as a result of portfolio grids and strategic planning matrices, the medical service lines have been considered important but not necessarily essential. Executives considered many service lines as overall drains on the system and, depending on the market, they were either relegated to second-tier consideration or evaluated for eventual reduction and jettisoning.

With the revised payments, all bets—or at least some of them—are off regarding the financial and operational value of the medical segment of the service-line portfolio. One example of this is the entire service line of oncology, which looks to gain significantly from the revised IPPS calculations.

Obviously, the broader categories of general medicine and other previously lower-margin areas will also undergo marked amelioration in reimbursement. This new

reimbursement translates into interesting planning dynamics, as executives may need to rethink their previously crafted strategies on market segmentation and service expansion.

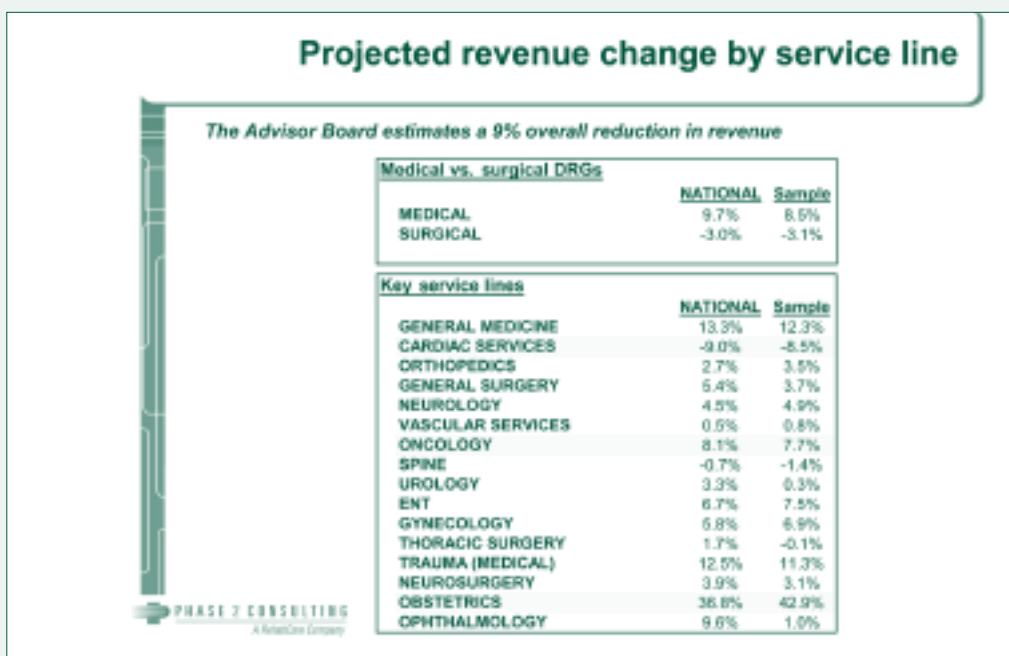
For example, in some markets, the Medicare segment is experiencing an increasingly difficult time accessing primary care, as more physicians close their practices to the over-65 population. Although this situation is somewhat understandable given the untenable payment levels the government has enacted, it creates a significant problem for many hospitals.

Medicare enrollees in smaller and mid-size markets are migrating to metropolitan areas where the oversupply of physicians usually fosters increased access to care. These migrating seniors, who are then referred to medical specialists in the metropolitan areas, often elect hospitalization in the metropolitan setting, thus leaving the hospitals in their locale in the lurch when it comes to Medicare patients.

This Month's

# Form

## Revised DRGs: Looking ahead



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**The salience of service lines**

The implementation of IPPS underscores one important strategic consideration and managerial approach, which is the inherent value of a service-line orientation.

Those organizations that have incorporated the structure of service-line management with defined data parameters, specific performance metrics, and well-defined managerial accountability will be better positioned to navigate the IPPS transition and adjust to the revised reimbursement guidelines.

By this time in the preparation cycle, organizations have been both warned and provided with ample lead time to make the necessary adjustments. When DRGs were first introduced in the mid-1980s, few organizations in the healthcare realm—or at least few hospitals—had a service-line structure. However, more than two decades have passed, and many organizations have astutely recognized that a service-line structure enables an organization—whether large or small—to more adroitly and nimbly make the transition to a new set of operational

and financial parameters.

This is a critical lesson that other sectors of American industry—and international firms—have learned well. The same can be said for progressive and strategy-driven health systems. The service-line structure offers organizations in transition—especially in payment transition—the optimal operational structure to assess the financial effect, as well as map out future strategy.

Some hospital executives have commented that the IPPS changes should be budget neutral for most hospitals. Although that may be true, there is a vast shift in the financial relevance between the service lines. A hospital's strategy should take into account that shifting relative value and reflect the revised importance of each service line under the new configuration. Those hospitals that have good data and service-line directors or managers who are ultimately accountable for their areas will be best positioned to adjust and map out a new strategic course under the new reimbursement guidelines.

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This Month's **Form**


**Revised DRGs: Looking ahead**

**Biggest losers**

Selected services	NATIONAL	Samsta
ORTHOPEDIC RECONSTRUCTION	-0.6%	-0.5%
STENTS, ALL	-26.3%	-27.6%
STENTS, DRUG ELUTING ONLY	-26.9%	-29.9%
PACEMAKERS	-12.7%	-12.1%
CABG	-5.3%	-5.3%
SPINAL FUSION	-6.0%	-4.8%
ICDs	-22.7%	-23.1%
STENTS, BARE METAL ONLY	-24.7%	-23.9%
HEART VALVES	-4.7%	-4.8%

- Some project cardiac service line total revenue decreases of 30%
- Forty percent to fifty percent reduction for some specialty hospitals

Full impact estimated between \$1.5–\$2.5 million



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**Book excerpt****Staff training should be an integral part of any provider's pricing transparency initiative in 2007**

Good training doesn't happen by accident. It requires planning as well as development of a needs analysis. A thorough, specific description of your goal in conducting this training program is important.

Avoid vague statements such as, "We will teach our staff a new process." A better goal would be, "We want to improve productivity by teaching staff a new process for best practices."

Even better is a specific goal statement: "We intend to improve patient cost access through staff use of the new retail project processes. Eighty-five percent of staff will be compliant with this new process by December 31."

Identifying business goals should be a team effort. Include finance executives, senior managers, subject matter experts, and champions and representatives of your target audience, and work together to achieve this task. Make goals as specific and measurable as possible. Ask yourself the following questions:

**1. What is the business goal you need to achieve? What business needs are driving the project?**

Create a process for increasing reimbursement by 9.5% (measurable) from alternative payment methods by providing cost-data access to the public. Successful implementation of the transparency project process is expected to be completed by 100% of front-end staff.

**2. How will you measure business results connected to the training project?**

Set a goal—9.5% increased reimbursement. An acceptable expectation might be a 7% increased reimbursement from self-pay and retail customers. The staff goal could be that 100% of front-end staff will use the new process by the year's end (measurable). An acceptable expectation could be 80% compliance. This will be determined by a manager audit or via test-patient telephone inquiries (specific).

The Microsoft Excel spreadsheet, which is this month's

training tool, is an example of a simple yet effective way to record audit measurement results to aid in the training process. Create meaningful column headings to record the data you are gathering. Using a spreadsheet program such as Excel also provides easy e-mail communication to team members who need to know training measurement statistics.

**3. What is the retraining plan?**

Every staff member and manager who does not comply with the rules outlined in the initial training session will undergo a second training session. Three months after the follow-up training, compliance (specific) with the training will be determined by test-patient telephone inquiries. The training team should reconvene (actionable) to examine the process to determine whether it is flawed.

**4. What are the learner's current abilities? What does the audience already know?**

This can be a challenging portion of the training process that you can approach in three ways. First, talk with managers after creating specific measurable questions, such as, "Is staff member X proficient in gathering insurance data 100% of the time?" Use the responses to gather the manager's knowledge of staff abilities.

Second, ask staff to write their answers to the same questions; sometimes there are surprises when comparing results.

Third, hold a question-and-answer session with the department as a group. This is a valuable opportunity to identify staff members who might need additional support in the training process. Ask the group to identify areas of specific concern or confusion.

**5. What do trainees need to learn?**

The answer to this question hinges on why you are conducting the training in the first place. Some reasons include understanding current CMS legislation; becoming proficient in using new software verification systems,

using chargemaster access systems, or directing clients to the organization's Web site to use price calculators; and learning how to direct callers to financial support consultants, provide retail prices, calculate a patient's financial responsibility for nontraditional insurance benefits, collect fees at the point of service, calculate a discount for self-pay patients, and conduct a preregistration outreach program to gather information required for the registration process.

Additionally, patient access staff sometimes need to learn investigative and research skills and to renew their dedication to customer service excellence.

### **6. Which resources are available to contribute to the training?**

Identify your champions and get them involved. Enlist the cooperation of the medical staff. Price transparency offers a significant value to your staff because it directly contributes to patient satisfaction. If you have medical directors, include them in the training as well.

If your staff have a favorite surgeon, pediatrician, or radiologist, try to bring this person onboard with the initiative.

In addition, creative training can be memorable. For example, consider an outdoor training session in nice weather. If your facility has access to a patio with tables and umbrellas, reserve the space for a few hours and hold an outdoor class.

Invite a local television or newspaper journalist to cover the training session and interview attendees. New activities that serve the community are newsworthy.

At the conclusion of training, provide staff with framed certificates they can display indicating that they were successfully trained. Or consider providing a special T-shirt, lapel pin, or banner for each participant.

### **Additional training tips**

If use of new software (e.g., real-time price-quote estimators and automated chargemasters) will be necessary in your price transparency initiative, your staff will need to become proficient with this software. In that regard, take advantage of your vendor's professional training ser-

vices. Once staff have had on-site vendor training, do not hesitate to contact the vendor if you are not satisfied with the trainer or if you need additional help. Vendors prefer their clients to be active users.

However, sometimes customers lack the confidence to use new applications, so be sure that your vendor agrees to return for retraining visits if needed and that a data or application expert is available to answer questions.

Request written instructions; staff will have questions once the trainers leave, and hard copy materials can reduce anxiety.

Besides offering training on new software, make sure that your training materials include clear, concise, and correct patient-friendly billing information. To that end, the Healthcare Financial Management Association, with support from the American Hospital Association and the Medical Group Management Association, created the Patient Friendly Billing Project.

The project has an excellent Web site ([www.hfma.org/library/revenue/Patient FriendlyBilling](http://www.hfma.org/library/revenue/PatientFriendlyBilling)) that contains articles and news updates on the subject.

Also ask your finance department training team member to provide a list of your major payers.

Visit their Web sites and search for "what-if" modeling options and real-time adjudication information. Share the information with staff so they can direct members to their insurer's Web site for additional information. ■

*Editor's note: PAA adapted this excerpt from the book Transparent Pricing for Retail Healthcare: Critical strategies to secure a competitive advantage, published by HCPro, Inc. Visit [www.hcmarketplace.com](http://www.hcmarketplace.com) for more information or to order.*

### **Questions? Comments? Ideas?**

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### Pricing transparency

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### Registration process

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### Up-front collections

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### Take the make up off for the third phase

Although much of the design work has yet to be completed, the group envisions the scenario eventually playing out as follows: The patient arrives in the registration area of a hospital ED. Somewhere in between registration, triage, seeing the provider, and discharge, a referral coordinator calls up the patient's information through a data exchange that links all participating providers. The information will reveal whether the patient has a PCP. If he or she does not, the coordinator will help the patient identify one and will then educate the patient about the availability of quality preventive care at area PCPs. The coordinator will also assist the patient in scheduling a timely follow-up appointment.

The NMPI will likely also contain demographic information, as well as the patient's discharge diagnoses, medications, and medical history.

Each provider will interface with the NMPI, including the EDs and PCPs throughout the St. Louis region. The database will include mostly Medicaid and uninsured patients but may eventually include all ED patients.

The implementation period is scheduled to begin in March.

However, in the short term, the IHN is conducting a pilot program to place two referral coordinators in two EDs.

"We want to make sure this is an effective model," Sehy says. ■

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### What an opportunity for evaluation

Whether you view the forthcoming effects of IPPS as significant or nominal, the change has additional value. As with any sweeping change that pervades the industry, it is an opportune time to evaluate not only the Medicare payment structure for its strategic implications, but also the organization's entire pricing structure. The reality is that shifting government reimbursement, transparent pricing, and strategically targeted revenue-cycle management practices (i.e., strategic pricing) are all interrelated.

Market pricing is very much one of the key items that the senior level needs to address. This narrow window of opportunity and transition provides leaders in the C-suite the platform to navigate this sea change with an entirely different view toward the horizon and a renewed focus on customer orientation and market-driven strategy.

This rebasing initiative provides an excellent opportunity for all hospitals and health systems to fully evaluate their cost structure and document their pricing approach and algorithms. The rapidly emerging trend toward transparent pricing—or perhaps more aptly termed "market pricing"—

synchronizes appropriately with the IPPS initiative to step back and evaluate the entire pricing configuration.

We are entering a time when progressive hospitals will realize the emergence of the customer and the diminishment of the chargemaster as market changes prompt the need for a new managerial model and approach.

Healthcare executives who are attuned to the shifting sands of the market environment will seize this opportunity and reevaluate their entire pricing structure by pulling up from their historical approach and drilling down into the fine detail of how they determine their prices and how this should optimally be performed under the emerging construct of a market-driven environment.

These planning-centric, forward-thinking organizations will capitalize on these significant changes to ensure future long-term viability. ■

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