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Simplifying the balanced scorecard for a better picture of performance

How one facility consolidated its approach

When the Hudson River Psychiatric Center (HRPC) in Poughkeepsie, NY, decided to develop a new service delivery model that would respond to the changing health care environment and provide vision for the future, it embarked on a major overhaul to assess the work of the organization. One of the outcomes was a balanced scorecard, neatly consolidated for greater efficiency and linked to the organization's strategic plans.

Jean Wolfersteig, MSPS, director for quality management and facility administration, and **Susan Dunham**, MPA, director of risk management and standards compliance for the HRPC, helped organize its scorecard. "We were pretty happy with how on-target we were," Dunham says. "We find it very helpful to have these measurements linked to our goals and objectives."

Being able to measure performance is the key to an organization's strategy. With the balanced scorecard, organizations can identify the primary areas to measure, whether they are customer relations, financial perspectives, technology, research, quality services, or a host of other areas that affect a health care organization.

The concept was developed for business and industry in 1992 by Robert. S. Kaplan and David P. Norton in their book, *Translating Strategy into Action: The Balanced Scorecard* (Harvard Business School Press). Health care has been slow in jumping on the bandwagon, but that has been changing

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in recent years as consultants and quality experts look at how a commerce-designed vehicle for performance improvement can translate to hospital management.

At HRPC, the organization began with a series of project activities that included:

✔ assessment of HRPC's readiness for managed behavioral care;

✔ comparison of the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) Hospital Standards and existing clinical indicators to assure that critical areas were addressed;

✔ development of a strategic plan that enhances the organization's readiness for managed care while meeting JCAHO standards;

✔ development of operation plans to support the strategic plan;

✔ development of the balanced scorecard following Kaplan and Norton's framework;

✔ use of the balanced scorecard's results in the selection and prioritizing of performance improvement activities.

The managers in charge of the readiness assessment developed a list of needs and a rating system that included these terms:

- minimally prepared;
- beginning;
- moderately prepared;
- well along;
- prepared.

The managers found they could rate most areas "well along" or "moderately prepared." However, two functions were rated as "beginning." For those, they developed specific needs such as goals and objectives for daily activities, performance appraisal programs, measures of satisfaction, utilization, quality and cost, and development of an automated medical record system.

The CEO, James Regan, PhD, guided development of the strategic plan that emphasized, among other things, staff training, reorganization of inpatient services, performance measurement, stakeholder awareness, and reduction of patient restraints.

"Dr. Regan's support has been crucial," says Dunham. "He was very involved and supportive."

Then came the balanced scorecard. According to Dunham, the hospital developed all new performance indicators, including process improvement, customer satisfaction, and clinical outcome measures, among others. **(See Patrice Spath's "Quality-Co$t Connection," p. 116.)** "We really

Four Perspectives of a Balanced Scorecard

Financial Perspective
- ❒ Operations within budget (overtime, unit expenditures)
- ❒ Cost-effective services (inpatient costs per day)
- ❒ Fiscally educated stakeholders (informed about resources)

Innovation and Learning Perspective
- ❒ Develop strategic competencies (targeted training, performance evaluations)
- ❒ Improve technology infrastructure (computer networks, training)
- ❒ Cultivate research and development (projects, papers, posters, presentations)
- ❒ Enhance employee motivation and empowerment (new skills, decision-making participation, performance improved activities)
- ❒ Product line development (clinical outcomes)

Customer Perspective
- ❒ Stakeholder satisfaction with services (quality of services, complaints, public opinion)
- ❒ Information sharing among stakeholders (informed, educated customers)
- ❒ Stakeholder involvement in governance and operations (response to concerns)

Internal Business Perspective
- ❒ Quality treatment services (census, program reviews, medical records standards)
- ❒ Enhance humane living environment (quality-of-life reviews)
- ❒ Provide safe living and working environment (occupational injuries, restraint usage, staff training, infection control rates, serious incidents, medications variance)
- ❒ Maintain accreditation and certification (Joint Commission on Accreditation for Healthcare Organizations, Health Care Financing Administration)

Source: Hudson River Psychiatric Center, Poughkeepsie, NY.

tried to come up with something not too overwhelming," says Dunham. But even with that directive, "it became obvious that our scorecard was too big. It had 18 indicators for satisfaction, including a lot of nondynamic indicators — they were measured only once a year — and there was a total of 44 indicators. It made us realize there is just so much we can attend to."

Ultimately, the scorecard was pared down to 20 indicators organized into four areas, labeled financial, customer, innovation and learning, and internal business. Each area has specific measurements. **(See box, at left.)**

Carolyn St. Charles, RN, MBA, president of St. Charles Consulting Group in Issaquah, WA, says that "the process of design and implementation in health care scorecards requires exquisite attention to communication with multiple stakeholders. It also requires ensuring their commitment and support from the beginning if the effort is to be successful."

Wolfersteig and Dunham say they tried to be very sensitive to stakeholders. Four of their outcome indicators involved stakeholder satisfaction with services.

A section for commentary is part of the scorecard. "In analyzing the data, some areas jump out at us as needing additional attention," says Dunham. "When that happens, we organize focus groups, do research, and initiate performance improvement activities. Basically, we're trying to enhance a safe and therapeutic environment while respecting our stakeholders and fostering growth and healing that will reflect progress in our care."

St. Charles emphasizes that the scorecard should be unique to the setting "in order to ensure a successful development and implementation."

Dunham notes that the HRPC scorecard is programmed for change as new factors influence the center's performance. "A lot is changing with the scorecard as a result of the exterior environment. Just three years ago, we were focusing on product lines. We thought we should carve out a specific market niche. But the marketplace has changed a lot in the last three years. The adult population here has been transformed. Sixteen years ago, 67% of our patients were over 65. Today we have less than 30 people in that age group." This is in a 200-bed psychiatric center. "We're dealing with younger people, more substance abuse concerns, and more forensic cases. That's what constitutes our market niche today."

Is the balanced scorecard working the way HRPC planned? After six quarters, the scorecard showed a 10% rate of overall improvement. The financial perspective area showed a 13% rise; the customer perspective area gained 5%; the internal business area rose by 15%; and the innovation and learning area improved by 9%.

When Wolfersteig and Dunham co-wrote the article "Performance improvement: A multidimensional model," (*International Journal for Quality in Health Care* 1998; 10:4) they began getting inquiries

about their scorecard. They also did poster presentations at performance improvements conferences in Melbourne, Australia, and Chicago, which resulted in even more inquiries.

"We've had requests from 70 or 80 hospitals for information on our scorecard," says Dunham. "There's tremendous interest from Australia, the Orient — 15 different countries in all."

Wolfersteig and Dunham conclude, "The scorecard has proven to be an effective tool in focusing the organization on achieving goals and objectives. The outcomes from the performance improvement activities linked to the scorecard represented significant improvements and, in some cases, cost savings. ■

How to tell if your QM department measures up

The balanced scorecard, step by step

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

The balanced scorecard (BSC) dates back to a study by the Norton Institute, which documented the feasibility and benefits of instituting a balanced measurement system organized around four perspectives. Today, the balanced scorecard is a tool used in many businesses to help people communicate, measure, and stay focused on strategic goals.

The BSC is a conceptual framework for translating an organization's vision into a set of performance indicators distributed among four perspectives: financial, customer, internal business processes, and learning and growth. **(See related cover story.)** Indicators are used to measure organizational progress toward achieving the vision and strategic goals. Through the BSC, an organization monitors both its current performance (finances, customer satisfaction, and business process results) and its efforts to improve processes, motivate and educate employees, and enhance information systems.

The financial perspective focuses on profit targets, cost avoidance, and cost efficiency, i.e., the ability to deliver maximum value to the customer. The financial objectives of health care organizations generally represent clear long-range targets as well as cost efficiency and the ability to deliver maximum value to the patient for each dollar spent.

The customer perspective captures the ability of the organization to provide quality services, the effectiveness of delivery, and overall customer service and satisfaction. Health care organizations have both internal and external customers that can be addressed by this perspective.

The internal business processes perspective focuses on the internal business results that lead to financial success and satisfied customers. The key business processes at which the health care organization must excel are identified and monitored to ensure that clinical and fiscal outcomes are satisfactory.

The learning and growth perspective looks at the ability of staff, the quality of information systems, and the effects of organizational alignment in supporting accomplishment of organizational goals. Processes will succeed only if employees are adequately skilled and motivated and supplied with accurate and timely information. To meet the demands of changing technology, external requirements, and customer expectations, physicians and staff may be asked to take on new responsibilities, which will require new skills, capabilities, and organizational designs.

Four perspectives

In each of the four perspectives, performance objectives are established. These are the critical success factors in achieving the organization's mission, vision, and strategy. If these success factors are not achieved, the result will likely be a significant decrease in customer satisfaction, system performance, employee satisfaction or retention, and effective financial management. Each objective is supported by at least one measure that indicates how the organization will measure performance against that objective.

Selecting and agreeing on measures in each perspective forces the people in the organization to define what is strategically important to them. To create focus, most organizations limit the number of measures to no more than 20. As the scorecard flows through the lower levels of the

Example of a Balanced Scorecard for the QM Department

FINANCIAL

Goals	***Measures***
Minimize costs	1. Actual labor/overhead costs divided by budgeted cost. 2. Ratio between work load units total FTEs.
Maximize cost avoidance	1. Savings realized from multiyear vs. annual buys. 2. Price trends for significant supplies or services purchased on a recurring basis.

CUSTOMER

Objectives	***Measures***
Customer satisfaction	1. Percent of customers satisfied with timeliness of reports. 2. Percent of customers satisfied with accuracy of reports. 3. Average time to return calls or voice mail messages.
Effective service partnership	1. Percent of customers satisfied with the responsiveness, cooperation, and communication skills of the QM department.

INTERNAL BUSINESS PROCESSES

Objectives	***Measures***
Data collection excellence 1. Accuracy 2. Timeliness	1. Percent of reports with no errors. 2. Percent of reports produced on time. 3. Number of committee discussions delayed/deferred due to inaccurate or unavailable QM report.
Case review excellence 1. Timeliness 2. Reliability	1. Percent of records reviewed within 10 days of patient's discharge. 2. Number of cases incorrectly identified as having failed screening criteria.
Data management excellence 1. Accuracy 2. Accessibility	1. Percent of computerized cases with data input errors. 2. Percent of requests for special reports that are processed within 48 hours of request for report. 3. Number of special reports requiring correction/rerun after initial review. 4. Percent of time computer is down or unavailable.

LEARNING AND GROWTH

Objectives	***Measures***
Quality work force	1. Percent of employees meeting mandatory qualification standards. 2. Percent of employees receiving annual performance evaluations. 3. Percent of employees attending mandatory orientation/continuing education sessions.
Employee satisfaction 1. Quality work environment 2. Executive leadership	1. Percent of employees satisfied with the work environment. 2. Percent of employees satisfied with the professionalism, culture, values and empowerment. 3. Number of unexpected employee absences (no prior notice).

organization, more measures will be added by individual departments, but these additional measurements should link directly back to the initial organizationwide measures established in each perspective.

While the authors of the BSC model originally intended it to be used as an organizationwide management model, a modified version of the tool can be selectively applied at the departmental level. If everyone in the quality management (QM) department has a clear understanding of his or her goals and targets, roles, and business processes, the department, as a whole, will succeed. The BSC goes a long way toward clarifying what the department is expected to accomplish and measuring the degree of success toward

those goals. If your facility has not adopted the BSC management model, it can still work for the QM department. The steps for creating a BSC for the QM department are listed below:

1. Define short- and long-term strategic goals for the QM department in each of the four BSC perspectives. The organization's vision and mission should be considered when setting departmental goals.

2. Decide what QM processes are critical to achieving those goals, then determine the best ways to measure the effectiveness of those processes. Select key performance measures the QM department should be tracking. Ideally, these measures link back to improvement goals that may have been established by the organization as a whole. **A BSC for the QM department in a hospital is shown in the chart on p. 117.** Strategic goals and measures for each of the four perspectives are listed.

3. Implement data collection and ongoing feedback (at least quarterly) to determine how well the department is doing at achieving its goals. Conduct regular departmental meetings to evaluate progress toward goal attainment.

4. Revisit and refine departmental performance measures on a regular basis to ensure that they continue to reflect the organization's current mission, which may change over time, and the strategic goals of the QM department. Scorecards only succeed when they provide relevant facts and data about current performance and show what needs to be improved, either immediately or in the future.

Departmental benefits

The scorecard can be a powerful change management tool when everyone in the QM department feels a sense of ownership and sees its value. Every individual should know what is being measured and how his or her work ties in with the measurement results. Sometimes the pressures of the changing health care environment can cause staff to lose concentration on what's really important to the QM department as a whole. The scorecard helps to keep staff focused on improvement priorities.

Developing a BSC for an entire health care organization requires an extensive commitment from leadership. For the scorecard to work, everyone from the top executives down needs to spend considerable time reaching consensus on the key performance indicators and then providing, collecting, collating, and analyzing feedback on the measurements that the organization deems critical to its success. If such a commitment does not exist in your organization, don't think the BSC can't be adapted for use in the QM department.

Initially, the scorecard was intended as an organizationwide framework for articulating strategic vision and measuring global results, however, with a few modifications BSC can be a powerful system for managing change just within the QM department. ■

Assessing JCAHO's core measures for surgery

Standards for SSIs could be in place this year

Of the 25 new ORYX core measures defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, some of the most unsettling questions concern the area of surgical procedures and complications.

Among the most troubling issues is the requirement that selected surgery patients be screened for surgical site infections (SSIs) within 30 days of surgery. The surgery measurements also include the timing for administration of preventive intravenous antibiotics. Both continue to raise questions in the medical community.

Many wonder how to handle the data reporting on SSIs so that the results are fairly assessed. Should there be a prescribed method for follow-up? Are postcards effective? Should someone be calling each patient? For hospitals with an already active directive for post-discharge surveillance, there are bound to be a greater number of infections reported. For those who do not proactively pursue these data, the numbers for SSIs will be much smaller, since there is no record of them.

"It's a real problem area," says **Paula Swain**, RN, MSN, CPHQ, of Swain & Associates, in St. Petersburg, FL. "Shorter lengths of stay aren't helping it either." Swain says there are three factors that really affect this:

1. A huge trust issue — doctors are coming forward, and if the doctor or the staff haven't followed through, there could be "fallout" into the physician's credentialing file.

(Continued on page 123)

(Continued from page 118)

2. Quality control — people may say they're doing the post-op interview, but if there's no response from a patient, it's hard to know if it's because the interview wasn't completed or the patient had no problem.

3. Aggregate analysis — can you be sure you have all the data and they are real and accurate?

Swain advises hospitals to address those problems by "using infection information to see what exactly you need to address and finding a physician champion and asking him or her to help devise a data collection methodology."

Sharon Springer, project director in the division of research at the Joint Commission, explains that JCAHO is in the process of putting together the technical specifications for the ORYX measures. "We've started with the acute myocardial infarction measures," she explains. "Then we'll go on to pneumonia, and the third will be for surgical procedures and complications. We're doing these specifications taking one measure at a time."

Springer says JCAHO is doing literature searches and looking at post-discharge surveillance methods. "We want to make sure we can identify the method that gives us the best quality of data," she says. "At this point, I don't know if there is any one best method. But we hope to standardize this by the end of the year."

Laura Harrington, practice director for external peer review at the Marblehead, MA-based Greeley Company, a consulting company which provides JCAHO survey preparation training, suggests that "to establish objective criteria, hospitals might start by looking at the factors that influence infection rates, such as clean vs. dirty procedures, instrumentation, surgical technique, and even the operating room environment."

Harrington says there are different structures for this in different hospitals, but recommends having an epidemiologist in charge of infection control. "When setting up a program to track infections, it's necessary to look at several criteria," including:

- total number of procedures;
- types of procedures;
- the physician involved;
- the surgical team;
- the room in which the procedures took place ("Look at the trend," she says. "Is it always room #13?");
- type of procedure;
- clean vs. dirty cases (such as colon resections).

"It's important when measuring all this to drill down hard on this kind of data," she emphasizes.

The ORYX measures also include the administration of surgical prophylactic antibiotics.

"Undesirable patterns or variations in the data may warrant investigation into prophylactic antibiotic practices," state the measure's description. "Studies that have evaluated these practices commonly identify inconsistencies in the time of the antibiotic administration in relation to surgery. To support examination of the relationship between the timing [of the antibiotic administration] and the SSI, hospitals are encouraged to participate in the surveillance and prevention of SSIs for the same surgical procedures."

"This is a very complicated issue," says Swain, "because administering the antibiotic is a highly integrated activity involving nursing, pharmacy, anesthesia, doctors, recovery room people, etc. They've got to get everything in order about 30 minutes before the knife falls. But anyone who has worked in an operating room [OR] knows that the scheduling is fragile." She points out that getting the right drug to the right practitioner who then gets it to the right patient at the right time is a real study in logistics.

"But hospitals are now trying to streamline the process," Swain says. "Some are delegating someone who can set up the process so the doctor can administer precisely when necessary."

Harrington suggests that hospitals take a look at the overall outcome. "Are you seeing an advantage to giving antibiotics pre-surgically? We're talking cost here. Of course, it's important to do it for high-risk patients such as those with comorbidities or cases that are typically more high risk, such as emergency abdominal surgery where there is no time to clear the stomach and bowel."

In some of the best practice scenarios, she says, "hospitals today are developing antibiotic task forces to look at outcomes and make a determination about administering these prophylactics based on types of cases."

There are a lot of factors that influence post-surgery infection. "When looking at infection control data for purposes of peer review," says Harrington, "take these factors into consideration. There is so much early discharge and home health care that you can't place all the ownership for these cases on the physician." She adds that sometimes the situation can become unnecessarily punitive. "Saying that the physician is in control is not always fair in today's health care environment.

Harrington says that peer review should not be done punitively. "There should be more help, more mentoring. Have a senior physician scrub and oversee surgeries where there are questions about the doctor or the OR staff."

Cases should be benchmarked against the national standards for that particular surgical procedure. For instance, we should look at the infection rates for open heart surgery across the country."

She notes that some hospitals create multidisciplinary infection control teams. They might even include maintenance managers to check the air filters in an OR and make sure other maintenance matters are up to speed. "It's critical to trend infection rates over time. Are the numbers really telling you something, or are they just too small to be measured at this time?"

While JCAHO is committed to reducing the number of SSIs, many questions remain regarding how to look at the infection numbers. Will hospitals be able to choose the procedures to be measured? Can that be done fairly? Will it produce quality data? How safe is the doctor's position when an infection issue arises?

Until precise measurement methods are prescribed by JCAHO, these questions remain unanswered. ■

Competency assessments: Handling them effectively

How to be prepared when JCAHO calls

Competency is a many-faceted area of hospital surveillance. There are a lot of areas a surveyor might probe.

Are your employees specifically up to speed in the areas where they work? Have your staff been provided with age-specific training? What about float and agency nurses? Are they being assigned appropriately?

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, is expected to focus on competency with age-specific needs, good documentation, planning and priorities, competency of float and agency staff, and training and records.

There have been suggestions that the JCAHO surveyors will actually pull resumes and match them to job descriptions, but **Donna Larkin**, a JCAHO spokeswoman, says there are no plans for that type of surveillance.

But it doesn't hurt to be prepared. "We take our job descriptions and the posted requirements for the job very seriously," says **Janice Blankenship**, SPHR, director of personnel at Boulder (CO) Community Hospital and a member of the board of directors for the American Society for Healthcare Human Resources Administrators (ASHHRA).

"If I say it's required, I make sure those requirements are met. At this point," she adds, "the Joint Commission says everyone with regular patient contact must pass the competency scrutiny."

This can mean maintenance workers and housekeeping staff, as well as the clinical professionals who are caring for patients each day. "In different jobs, these competencies mean different things," she says.

Do the cleaning people understand they can't leave potentially dangerous chemicals lying unattended on a pediatric floor? Do the maintenance people know the precautions to take in an ICU unit when the air conditioning stops working? Do the rehab staff understand the use of treatment and education with small children or delicate geriatric patients? Are transporters trained to handle patients with a wide variety of accompanying infusions?

And what about nurses and aides? Can they communicate effectively with all age groups and those with cultural differences? Are they trained to spot signs of abuse in children and older people?

"It's quite challenging to meet the standards for the Joint Commission because they're so very specific," says **Cindy Harrison**, director of Human Resources at Chelsea (MI) Community Hospital and president-elect for ASHHRA, "Depending on the surveyor, the focus changes, and you're not sure what to be prepared for."

One of the challenges, of course, is defining competence. Often, it can be determined from a supervisor evaluation and performance review. Sometimes it becomes an issue when a family or patient issues a complaint.

"One of the big things the Joint Commission focuses on," says Harrison, "is age-specific competency. We write them into our evaluation and performance review materials. Competencies are very clearly outlined." And how does a hospital test for competency? "Some of it is [by] written test," she says, "and some of it is peer review. When we bring in new hires there is, of course, a complete orientation. Each new hire is paired

with a mentor who's responsible for monitoring and directing the employee in the new position. Nurse managers are expected to observe new employees very carefully."

All of this, of course, must be carefully documented to be of any use in a survey.

There are a number of ways to assess competency. Some recommendations are conducting paper and pencil tests, asking a technician to explain a complicated procedure using simple language, staging mock disasters, and implementing competency-based job descriptions.

"We have a nurse education day where we go over competencies," says Harrison. "And any time there's an incident or a complaint by a patient, visitor, or doctor, we look into it immediately and retrain where necessary."

She says that maintenance and housekeeping staff go through competency procedures just as specific as those for nurses and technicians. "They're assessed for their job. For instance, we need to know that if they're working in a patient's room, they are able to communicate effectively and appropriately."

Assuring competency for float and agency staff is another challenge, says Blankenship. "We stipulate to the agencies that provide temporary help that it's up to them to do competency evaluations, which we then review. We also audit health care agencies to see if they're doing the appropriate assessments."

Cultural differences are also addressed in Chelsea Community Hospital's human resources department. "We're doing an inservice soon for all staff working with patients that specifically aims at working with diverse patients," says Harrison.

"In a nutshell, we'll be looking at cultural differences, customs, and being sure the patient understands the physician and nurse treatments and assessments," she says.

Harrison also wants the staff to understand that there's more to diversity than country of origin or color of skin. "Age, gender, etc. play a role here too," she explains.

"It's always a challenge to be able to assure the competencies acceptable to the Joint Commission," says Harrison. "But on the other hand, it makes us provide better care and pay more attention to these matters which are important." ■

Knowledge of denials is power for hospitals

With data, health system holds payers accountable

Health information management personnel know that improving reimbursement requires a team effort across an organization. Such an effort took place at Baycare Health System in Clearwater, FL, where key players from patient access, case management, and patient financial services came together to develop a denials database.

That database is helping to correct misconceptions about lost reimbursement and is putting pressure on physicians and other clinicians to become part of the solution, says **Martine Saber**, CHAM, regional director of access management.

The new system has shown that, by far, the most payment denials — in number and in dollar amount — are for clinical reasons, such as medical criteria not being met, rather than for technical reasons, such as access personnel not calling for authorization, Saber says.

Armed with the information the database provides, hospitals throughout the 10-facility system are setting goals for reducing write-offs and denials, and clinical departments are joining the effort, she adds.

"Once [facilities] learn they're doing services for free, they say, 'Of course we won't do that.' It's really an education issue," Saber says.

Already the hospital has brought to the table one large managed care company and said, "We expect payment on these denials that we consider to be unjustified," says **Donna Miller**, MHS, special projects coordinator for Baycare's continuum department. "We're moving forward in our communication with managed care companies. We realized that a lot of the issues we thought were related to the hospital service side turned out to be related to the physicians."

One example is when physicians cover for each other over the weekend and don't feel comfortable discharging someone else's patient. Another is when patients are admitted who don't meet the criteria for an inpatient, Miller adds.

Saber notes, in some cases, physicians are giving access personnel the wrong authorization number for a procedure. "Just because they got an authorization to do a consultation doesn't mean it will cover the procedures ordered [as a result]."

The continuum (case management) department began the effort on the denials database by

deciding to look at the patient days in the hospital that were avoidable — those that occurred, for example, because a procedure wasn't ordered in a timely fashion, Miller explains.

"We came up with a list of 30 reasons we have avoidable days," she says. "We code those and run a report every month. Then we asked, 'How often are avoidable days costing us? How often are we being denied reimbursement for that day we identified as being avoidable?'"

Baycare has identified the top 10 reasons for avoidable days and is working to reduce those as part of its quality improvement focus this year, Miller says.

Meanwhile, patient accounting was "starting to feel the brunt of managed care denials, but there was no central place where they could be processed, reviewed, documented, and worked," she says. "Since we didn't have a united front in fighting denials, we were not very successful at showing, (1) that we needed to be paid for a day, or (2) that we agreed with the managed care company and accepted responsibility."

There also was no tracking mechanism that allowed the continuum department to know how successful it was in getting denials turned around through the appeals process, Miller says. Through the database, she discovered that in many cases her department had been writing letters and submitting appeals for denials on accounts that had already been written off by patient accounting. "There was no central way for everyone to communicate."

The denials database works this way:

• Whoever receives the denial enters the information in a special field in the registration system, which is from Malvern, PA-based SMS. The account is tagged with an "X" for a technical denial and a "Y" for a clinical denial.

• At midnight, the SMS system populates the database with all the accounts that were denied.

• A list automatically is sent to the database: the names of the primary care physician and the insurance company, expected charges for the account, expected reimbursement, the amount outstanding from the insurance company, and how much is written off.

• The continuum department manually enters its findings on whether or not the denial was justified, and how many patient days met medical criteria and how many did not.

• Anyone working on denials can go to the database and see actions taken — for example, that for one case the continuum department has already decided the denial was justified, and for another, an appeal letter has been written.

• If an employee identifies a denial and calls the insurance company or corrects an authorization number, that person tags the account as a rebill account, which alerts patient accounting to reissue the bill.

• If it's determined that an error was made and the denial is justified, staff in patient accounting know to write off the bill immediately, thus reducing accounts receivable days.

The database has illustrated that "there are a lot of opportunities for physicians to partner with us when trying to determine a discharge plan for the patient," Miller says. When physicians fail to properly classify a patient, it puts the hospital in a position where it is not allowed to get an authorization number, she notes.

"The physician is responsible and accountable for the correct authorization," Miller says. "The managed care company might say [to the physician], 'We'll pay you for that as an observation [account] even though we initially gave you an inpatient authorization.'"

The physician can change that designation and still be paid, she says, but according to Medicare rules, a hospital cannot change a patient status for reimbursement purposes only.

"We've been trying to get a determination from the Health Care Financing Administration as to whether we can change [an account] from inpatient to observation as long as we're looking for a lesser payment," Miller adds. ■

Continued financial woes for hospitals, study finds

A recent study indicates that the Balanced Budget Refinement Act of 1999 (BBRA) has not quelled many of the financial problems facing the nation's hospitals. The study, "The Financial State of Hospitals: Post-BBA and Post-BBR" — conducted by Ernst & Young LLP in Irvine, CA, and HCIA-Sachs LLC in Evanston, IL — shows

that despite the passage of the BBRA, U.S. hospitals continue to show declining hospital profit margins. The study used 1999 data in its calculations.

The study found that nationwide total hospital profit margins have significantly fallen from pre-BBA (Balanced Budget Act of 1997) levels. The BBA caused total margins to decline from 5.5% to 2.9% in 1999, with the BBRA providing minimal relief, according to the study. Hospitals are expected to experience their lowest margins since 1984.

Smaller, rural hospitals are in the greatest financial jeopardy. By 2001, hospitals with less than 100 beds are estimated to report profit margins of less than 1%, the study says. By the end of 2004, the end of the five-year scoring window for BBRA, nearly 60% of all hospitals will be losing money, according to a study conducted by the Lewin Group in Falls Church, VA.

"The effect of these two studies cannot be ignored. Many hospitals will likely experience bond downgrades, loss of capital equipment, and a reduction in staff," says **Michael Hamilton**, partner and national director of Ernst & Young's Health Care Advisory Business Services.

For a copy of the study visit HCIA's Web site at http://www.hciasachs.com or Ernst & Young at http://www.ey.com/industry/health. ▼

Final rule exempts data bank from Privacy Act

The Department of Health and Human Services Office of Inspector General in Washington, DC, published a final rule on June 1 exempting the new system of records for the Healthcare Integrity and Protection Data Bank (HIPDB) from certain provisions of the Privacy Act. The Health Insurance Portability and Accountability Act of 1996 mandated a national data bank to provide a database of certain final adverse actions taken against health care providers. The effective date of the final rule was June 1. Final regulations for the HIPDB were published in October 1999, along with a proposed rule to exempt the new system from some Privacy Act requirements.

The exemption in this final rule applies to investigative materials compiled for law enforcement purposes, according to a review of the rule by the Joint Healthcare Information Technology Alliance in Washington, DC. The rule exempts the data bank from those provisions in the Privacy Act that protect from release to the subject of the record and information on law enforcement queries to the data bank and exempts the data bank from Privacy Act access and amendment procedures to establish access and amendment procedures contained in the HIPDB regulations.

Record subjects would be guaranteed access to and correction rights for substantive information reported to the HIPDB. The Privacy Act procedures use access and correction as a basis, while providing additional rights, according to the final rule. In addition, data bank subjects would have broader rights on HIPDB correction procedures, including the right to file a statement of disagreement as soon as a report is filed with the HIPDB. ▼

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'Honest mistakes' won't be criminalized with OPPS

The federal Office of the Inspector General (OIG) said it won't take civil or criminal action for billing errors due to what it calls "honest mistakes" or negligence during the implementation of the new outpatient prospective payment system (OPPS). "The hospital will be asked to return the funds erroneously claimed, but without penalties," wrote Inspector General June Gibbs Brown in a letter to American Hospital Association (AHA) president Dick Davidson. OIG will consider:

- the rule's clarity;
- the complexity and novelty of the OPPS billing system;
- the quality of guidance issued by the Health Care Financing Administration and/or fiscal intermediaries;
- the extent to which the provider has tried to understand the rule;
- whether the provider has an effective compliance program.

The letter can be viewed at http://www.hhs.gov/oig/new.html. ■

SourceKit

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