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Patients go out of their way for treatment at St. Joe's

Standards of excellence are part of the routine

When patient access services manager **Stephanie Holland**, RN, CHAM, heard of a north Georgia couple who had driven well over an hour — past several well-known and much closer facilities — to receive emergency cardiac care at St. Joseph's Hospital in Atlanta, she was gratified, but not really surprised.

The husband and wife thought of St. Joseph's, they said, because friends had told them its emergency department (ED) personnel not only provided top-notch clinical care, but also seemed dedicated to making the experience as convenient and nonstressful as possible.

It's no accident, explains Holland, that the 346-bed tertiary care hospital is one of 17 acute-care facilities designated a magnet hospital by the American Nurses Credentialing Center of the Washington, DC-based American Nurses Association. St. Joseph's has been part of the Magnet Recognition Program for Excellence in Nursing Services since November 1995. To receive that designation, the hospital met 14 criteria.

At a time when forward-thinking access leaders are stressing the importance of nursing expertise at the point of service, St. Joseph's appears to be ahead of the trend. Seventy-five percent of the hospital's employees are nurses, as are the top three access staff members. **(See related story, p. 111.)**

Although the Catholic Health East (CHE) hospital consistently scores well above the average of the 32 hospitals in the CHE system in several admissions and customer service categories, there is no resting on laurels, says Holland's boss, **Kim Sharkey**, RN, MBA, CNAA, director of nursing administration.

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Multiple benefits gained with enterprise scheduling

✔ *Politics, technology are among the challenges*

The benefits of consolidating scheduling and registration across the enterprise are many, but so are the challenges involved. Carol Miller of Superior Consultant Co. looks at what's involved to create a successful process and how to overcome tradition, departmental silos, and incompatible technology 114

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✔ *Hospital gets a grip on MSPQ process*

Sarasota (FL) Memorial Hospital didn't waste time when a Medicare audit found problems with the way the Medicare Secondary Payer Questionnaire (MSPQ) was handled. Extensive, repetitive training was the key, along with a dual software solution that doesn't allow bills to be sent to Medicare without the proper MSP information. The daily dollar amount of accounts waiting for a missing MSPQ before they could be billed has gone from $1 million to $50,000 116

APC solutions? Please call

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Does your hospital consider its outpatient flow a best practice as related to APC implementation? If so, personnel at Touro Infirmary in New Orleans would like to make a site visit. They are interested in facilities with diagnostic and recurring outpatients in multiple entities, including medical/surgical 117

Insurer's Web site cures access blues

✔ *Work is done in real time*

Access personnel in South Carolina can log on to a Web site that allows them to check insurance eligibility or claims status, obtain patient authorizations, and see whether a patient has met the deductible, among other features. It's available seven days a week, 24 hours a day, in real time. Could SouthCarolinaBlues.com, an innovation of Blue Cross and Blue Shield of South Carolina, be the wave of the future? 117

COMING IN FUTURE ISSUES

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- Designing access from the ground up
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"There are 10 standards of excellence **[see box, p. 111]** that we go over with employees the day they're hired, and they're evaluated on those standards every time they have an evaluation," Sharkey says. "We give them an insert that they carry around that includes the standards, the hospital mission, and the customer service policy. At least monthly, we bring up one of the standards at the hospital director-level meeting, then at the staff meeting and in the employee newsletter."

That standard-of-the-month might be, for example, "present a professional image" or "anticipate the needs of the patient," Sharkey says.

In addition to regular surveys by the National Research Corp. in Lincoln, NE, in which St. Joseph's results are compared with a national database and with its CHE sister facilities, she notes, the hospital nurtures its customer service with these efforts:

- Individual departments follow up on their own calls and survey cards.
- The Caught by an Angel program places cards throughout the hospital that patients and their families may fill out to give recognition to a particular employee.

Exploring standards of care

To become part of the Magnet Recognition Program for Excellence in Nursing Services, the hospital met 14 criteria, broken into standards of care and standards of professional performance, Sharkey says. The six standards of care are assessment, planning, diagnosis, implementation, identification of outcomes, and evaluation. The eight standards of professional performance are quality of care in administration practice, education, research, collegiality, resource utilization, ethics, performance appraisal, and collaboration.

Volunteers are an integral part of the access department's customer service initiative, Holland points out, and in late July, their role was changed to further enhance the effort. "Instead of the patient coming [for assistance] to the volunteer behind the desk, we're now asking the volunteer to go to the patients, to greet them as they come through the door of the main admitting lobby."

To make access staff more easily identifiable to patients, the department implemented a uniform policy on July 1, she says. Access employees are asked to wear khaki pants or skirt, a white blouse or shirt, and a navy sweater or blazer, with a

St. Joseph's Hospital Standards of Excellence

1. Present a professional image.
2. Communicate effectively.
3. Maintain privacy and confidentiality.
4. Anticipate needs, demonstrate initiative, and strive to exceed expectations.
5. Be an ambassador for your hospital.
6. Be a team player.
7. Know the hospital.
8. Assume responsibility for cleanliness.
9. Take ownership of complaints.
10. Celebrate successes.

navy tie for men. Although the results have been positive overall, the policy needs fine-tuning, Holland adds.

"[The uniform] is not as recognizable as it should be," she says. "People have translated the policy a little too liberally, with some getting creative and tying on a blue scarf. We're looking at going to a more tailored look."

A computer conversion in February 1999 lent itself well to the hospital's customer service ideal, Holland says. St. Joseph's switched to Last Word, the admission / discharge / transfer system of Seattle-based IDX, which includes an ED module that makes the nurse the patient's first contact, she adds.

Under that system, the nurse is the first person to interact with the patient, performing a brief triage and setting up a temporary medical records number, Holland explains. "After that, depending on the diagnosis, the patient is either sent to the back for treatment or is waiting in the lobby. At that point, we register the patient, and we do have computers in each of the ED treatment rooms."

In addition to meshing well with EMTALA concerns, she notes, the system allows staff to see the ED census at all times. "We always know who is in what room. We can assign a patient to a room without relying on an erasable board. We can see who's waiting, who's triaged."

In the future, electronic communication will be implemented between clinical and registration staff, Holland adds. "We're looking at how to use an electronic messaging board so that a nurse can notify a registrar that a patient has been upgraded to observation or inpatient status. The floor nurse would be able to access the system and see that."

At present, Holland says, the process is manual, with nurses having to hand a piece of paper to registrars in the admitting area to alert them to such changes. To facilitate that process, the decision was made recently to place a registrar in the ED, Sharkey notes. "[That employee's] goal is to assist the registrars outside the ED, so instead of those outside walking into the ED to do bedside registration, the one inside will do that."

The ED registrar also will keep track of patients moving out of the ED and being upgraded to inpatient status, and he or she will collect cash payments for co-pays and deductibles, she adds. ■

Hospital leads trend of nursing in access

'It only makes sense'

If more nursing expertise in the access department is the way to go, St. Joseph's Hospital in Atlanta has a head start. Overseeing the department are two registered nurses — the manager for patient access services and the manager for nursing support services — who report to the director of nursing administration.

"With RNs making up 75% of our hospital employee base, it only makes sense for an RN to lead the access management team because it plays such an integral part in the patient accessing the hospital system," explains **Stephanie Holland**, RN, CHAM, the manager for patient access services.

Holland oversees the hospital's cashiers, registrars, financial counselors, insurance verifiers, and an education specialist. Her colleague, the manager for nursing support services, is in charge of patient placement, central scheduling, and case managing transfers into the hospital, she adds. Their boss, **Kim Sharkey**, RN, MBA, CNAA, reports to the hospital's chief nursing officer, who also is vice president for operations.

"The whole admissions department used to fall under the business office," says Sharkey. "We found that if we could put the front-end processes and nurse staffing in one area, under nursing, we'd know where the patients are coming in, where they're going, how we would staff for them, and how they would pay."

It works well, she explains, because access personnel can determine immediately which bed a patient will occupy and what staffing will be necessary. "Central scheduling [personnel] can say, 'We have an urgent patient coming in. We need a bed in the intensive care unit [ICU],' and [the nurses] know what kind of questions to ask. Because we are nurses, we also know physician preferences. We know the physician prefers the patient on this unit rather than that unit, and it saves a lot of frustration."

As a nurse who has worked on the floor and in the ICU, Holland points out, she is equipped to view the patient's care globally, "from clinical to nonclinical and from the financial perspective. We see the whole picture from admission to discharge, and we can help initiate that process a bit better."

Having a nurse who understands physicians' orders and instructions and who works with physicians to expedite the admission of a patient makes the access process go more smoothly, she says. The manager for support services, Holland notes, "really is a liaison between the hospital and the physician's office in placing the patient appropriately."

Directing patient traffic

About 60% of St. Joseph's patients are urgent direct admits from outlying facilities, and her colleague case-manages those patients who are directed to a hospital room, the catheterization lab, or the operating room, she says. "He talks on the telephone all day long, placing urgent direct admits from across the state of Georgia and expediting transfers."

The manager for support services prevents delays in getting care for patients, she adds, at times printing out the blue patient stamp plate and the armband for the operating room nurses when an admit is going directly to the OR.

Nursing expertise also comes in handy, Holland says, in understanding what insurance companies will cover with regard to patient type. "If a physician wants to admit a patient who is in need of a heart catheterization, we will give that patient ambulatory status to begin with, then oversee that whole process and upgrade the status [to observation or inpatient] if necessary."

If the patient isn't upgraded, the insurance company won't reimburse at the proper level, she says, and it's time-consuming to change status back to ambulatory if the patient does not meet the observation or inpatient criteria.

In the area of financial planning, Holland says, her nurses' empathy for patients comes into play, complementing St. Joseph's philosophy of charity care. "We refer to it hospitalwide as the financial continuum, knowing how important the care continuum is clinically," she explains. "We have a nursing care plan, and we have somewhat of a financial care plan. The whole access management system is part of the financial continuum, which overlaps with the patient care continuum.

"We want patients to be mostly concerned with getting better," Holland says, "and we're here to help them give that the priority." ■

On-line booking smoothes discharge

At-risk patients identified electronically

Hospital access managers who count discharge planning among their areas of responsibility may be interested in a new on-line reservations and booking system that promises to revolutionize the discharge process.

Personnel at selected hospitals in the Northeast are using a new software tool to determine the availability of post-acute services, then request and schedule those services over the Internet, says **Ruth Fisk**, RN, MS, vice president of clinical operations for Integrated Health Networks (IHN), the Newton, MA, company that produces the software.

The system is one way to help bring the admitting process into the electronic age, says **Jackie Birmingham**, RN, MS, CMAC, IHN's vice president of network integration. "With eDischarge, the identification of a patient who is at risk can be done electronically. The access person can automatically trigger a referral to the case manager."

That process is in keeping, Birmingham adds, with the ideal of having admitting personnel screen patients for certain high-risk criteria for discharge planning, including such factors as age, diagnosis, and living situation.

"Access people have a lot more information than they believe," she says. "I don't think they know they can influence length of stay merely by having a suspicion of discharge problems. [Admitters] should have some training on how to look at the total patient, not only the admitting

diagnosis. The admitting diagnosis is wrong a great deal of the time."

Three-month pilot projects of eDischarge were completed in mid-June 2000, adds Birmingham, a veteran discharge planner and case management consultant. The new system is now available commercially to other hospitals. It works like this:

- The post-acute care provider taking referrals from a hospital, skilled nursing facility, home health service, or rehabilitation facility completes a profile outlining the services those facilities offer. Each day, the provider updates bed or service availability.
- Hospital or other facility case managers or discharge planners working on a discharge plan input the patients' care needs and the date the hospital would like to discharge them. At this point, the specific patient is not identified.
- The system matches the availability of facilities or services with the needs of the patients.
- The facility's discharge planner sends a notice via e-mail to the matched post-acute care provider, by way of a secure Internet server, that a bed or service is being sought.
- The post-acute care provider's intake coordinator reviews the patients' care needs on the Web and responds to the facility's discharge planner.
- The patient and/or family is consulted in the final selection of the post-acute care provider.
- To protect patient confidentiality, patients' identifying information is sent to the provider only after the final match is made.

An electronic schedule

All communication among levels of care is done through electronic messaging, and the time given to respond is limited in both directions, Fisk points out. "If providers don't respond within a specified time, they're no longer on the list. This arrangement is agreed upon before providers are enrolled in the system."

IHN recommends, based on information from focus groups, that the nursing home or home care service be given two hours to respond to the hospital regarding acceptance of the patient, Birmingham says. "The provider needs to make a decision that it will either take the patient or not, or will send a nurse to the hospital to assess the patient."

If the provider sends a nurse, it will be given another two hours before the process goes to the next step, she says. "In fairness to both sides, the provider should either do an assessment of the patient within two hours or respond to the hospital and let them know a liaison will be there in three hours."

Whatever happens, Birmingham points out, the hospital's case manager or discharge planner can override one choice and go on to the next.

Shortening discharge arrangements

Some nurse liaisons who do preadmission assessments have expressed concern that the online discharge system will prevent patient screening, but that is not the case, she emphasizes.

"We want the patient to be screened for appropriateness to the nursing facility or home care service," Birmingham says. "We believe that once discharge planners and post-acute providers gain experience with the system, the appropriateness rate will improve significantly and only a few patients — in cases where the patient's needs are complex or where the destination isn't sure because of the complexity — will need to be screened."

One big advantage of the IHN system is that "there is a considerable reduction in the amount of time that has to be expended in making discharge arrangements," Fisk says, "not just elapsed time, but time spent communicating with providers. Who has a bed? Who will accommodate certain requirements? We hear from case managers who now can spend an hour or two on the phone just determining who has a bed available and the appropriate services for the patient."

The system eliminates such distractions as busy signals, multiple faxes, and the need to leave and respond to voice messages, she adds. "It has been reported that the typical hospital discharge conducted via telephone and supported by paper, on average, may take more than four hours to complete. The same transaction conducted electronically is estimated to take less than 45 minutes to complete."

IHN can make program enhancements to meet the needs of individual organizations, Birmingham notes. The state of New York, for example, requires something called a "Patient Review Instrument," she says. With eDischarge, hospital personnel are able to complete the form on-line and submit it electronically.

"We also are able to enhance the assessment questions that a hospital would want to ask about discharge, then collect that data and report on it," Birmingham says. "There is a data

bank within the [eDischarge] assessment tool, so we can add questions. We're now up to about 700 questions."

This high-tech discharge solution can facilitate closer communication among families, Fisk points out, particularly when family members are spread out in different parts of the country. "The general perception is that high-tech is more impersonal," she says, "but in this instance, it really does expand the circle to include family, even if distant, and allows them to know the options and advantages of one facility or service vs. another."

A feature of the IHN system, adds Birmingham, will offer "patients and distant families access to what we're doing. We can e-mail the Web sites of nursing facilities to the families, where they can see a review of the nursing homes. They will have a unique code or password that will give them access to designated information that they need to make a decision."

Finding the best fit

What is important about the IHN program, she says, is that it is designed as a "workflow tool for professionals that will allow discharge planners to spend time with the family and the patient instead of the fax machine."

Many patients go to two or three levels of post-acute care before finding the level that fits their needs, Birmingham says, often because they don't go to the right place the first time. The IHN system will make a difference, she predicts, "because the discharge planner will have a workflow tool, and the patient is matched to the provider based on needs and availability. Discharge planners also will have more time to work with the complex patient to develop a more precise discharge plan."

Response to the idea has been phenomenal, Birmingham adds. "There is communication only when there is a piece of information and discharge planners don't have to wait for a phone call. I call it the 'virtual discharge plan.' Payers are also very excited about the workflow tool, since it will allow more real-time information and collaboration with hospital-based staff and post-acute providers."

[For additional information on Integrated Health Networks, contact Ruth Fisk at (617) 630-1335 or ruthfisk@ihn.com or Jackie Birmingham at (617) 290-3365 or jbirmingham@ihn.com.] ■

GUEST COLUMN

Multiple benefits gained with enterprise scheduling

Politics, technology among challenges

By **Carol S. Miller**, MBA
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Many hospital- and university-based systems are evaluating the concept of a centralized registration, scheduling, and confirmation center to handle most, if not all, registration and scheduling activities across the enterprise. Those who initiate this consolidation recognize the value and efficiencies to be gained from centralizing front-end office functions. In the future, many expect to gain additional efficiencies by including physician practice front-end functions in the centralization.

This article explores the benefits to be gained by integrating access services, the issues that organizations will confront during the consolidation process, and future benefits to the consolidated center from emerging technology.

Benefits of centralized services

Despite the hurdles to overcome in changing an organizational structure, workflow pattern, and employee skill set, the change to an integrated service function brings many rewards to the hospital, physicians, and patients.

- **Customer service.** Most facilities currently have multiple telephone numbers for registration and scheduling, including surgery scheduling, outpatient registration for routine diagnostic tests, direct or planned admissions, walk-in or clinic services, as well as special procedures in cardiology, radiology, and nuclear medicine.

With an integrated center, skilled and trained personnel will be able to handle the registration, scheduling, and confirmations in a consistent, one-call, one-stop manner. With a centralized rules-based service, multiple tests in different departments can be scheduled contiguously, factoring test and travel time between appointments, and pretest orders and communication

can be consistent. As a result, delays in processing are virtually eliminated, registration and scheduling time cycle diminishes, patient flow-through improves, and communication breakdowns dramatically decrease. That simplified process increases physician and patient service satisfaction and dramatically improves their perception of the facility. In addition, with enhanced communication and efficient processes, physicians are less willing to recommend the services of competitors.

• **Marketing augmentation.** Improved communication and service mean that marketing can communicate the service element to patients and physicians, as well as use that information in its overall marketing approach to the primary and secondary communities. It becomes a selling point, a branding, to one and all.

• **Increased revenue and cost reductions.** Through a detailed, consistent front-end process, staff will be able to obtain accurate demographic and insurance information, eligibility, and authorization before the visit; secure copayments at the time of service; and significantly decrease no-shows through the contact and appointment confirmation process.

Those improved work processes dramatically reduce rework in the back-end functions, resulting in full-time equivalent savings in billing and collections. Days in receivables are reduced and revenue capture increased when overall billing information is improved by eliminating isolated pockets of manual, semimanual, and decentralized registration. Centralization also allows the organization to track resource utilization and productivity more efficiently.

• **Physician, hospital, and patient linkage.** A centralized registration and scheduling service provides a seamless operation among multiple departments and providers of care. That process alone improves the communication among all entities and strengthens the confidence and reputability of all involved.

Issues to be confronted

The change process is not as easy as might be expected. There are lessons to be learned from organizations that have embarked on consolidation of front-office functions. As hospitals begin the change and reengineering, they sometimes believe that executive management agreement on respective reorganization will lead automatically to appropriate staff placement or required cross-training. Several have begun the process only to be caught in the milieu of politics, personnel issues, and hospital traditions, creating setbacks in realigning the organization. Here are several issues that can affect the organization:

• **Breaking tradition.** Over the years, hospitals have been performing the same business with similar day-to-day functions, using the same staff for the same services. Changes affect the lifestyle, habits, and security of those individuals and often result in noncompliance, passive aggressive and disruptive behavior, resistance to change, or resignation.

• **Departmental silos.** Some department staff and leaders tend to protect their territory as if they are the only individuals who fully understand the integral services and accurately provide pretest information, description of tests, and appropriate scheduling times. Those individuals want to continue to control all aspects of their business unit, place roadblocks to change, and destroy employee morale and initiative, and they are unwilling to conform to new structures.

• **Incompatible technology.** With consolidation, many if not all of the hospitals have experienced varying levels of technological incompatibility, including software or hardware inconsistencies, multiple dissimilar names for the records of a single individual, different test names in multiple systems, and overall database incompatibility. Those incompatibilities result in delayed implementation and discouraged employees. Even the process of deciding on the best software or hardware is cumbersome.

• **Space.** All hospitals have space issues, making reorganization of departments and staff difficult. Even though the on-line services with centralized registration and scheduling can be virtual, most hospitals have not fully understood or embraced that concept. Therefore, many organizations are still trying to realign departments in nonideal spaces.

• **Inconsistent skills.** When registration processes are carried out in multiple locations by multiple staff, each employee receives different training and develops a different skill set. That produces an inconsistent registration and scheduling experience, plus mixed interactions with patients and physicians, resulting in negative impressions of the organization.

To create solutions to those problems, the consolidation of front-office functions needs to be clearly mapped, with careful attention to the people and processes affected. Working through the people and process barriers includes these steps:

— building a shared vision of the outcome of easy access for customers and physicians;

— involving the people who own the work function in the redesign process;

— tapping the managers who will reap the benefit or failure of the redesign process in the development of rules, standards, and training manuals;

— choosing for the initial consolidation those functions that can provide an early win for all involved.

Solutions also may include:

— ongoing education and communication of the change process;

— responding to negative feedback;

— placing individuals in appropriate positions;

— offering choices;

— making a site visit to another facility to see the end results;

— developing special targets or rewards for achievement.

Services for the future

As technology, Internet connectivity, communication resources, and system integration improve, patients and physicians will realize the luxury of registering and scheduling via Internet connections. That is true regardless of the hospital, physician practice, specialty, subspecialty, or the patient's location. For example, a physician completing an examination will be able to register a patient for follow-up tests or other procedures before the patient leaves the office.

A patient will be able to register once — within the physician's office, for example — and demographics and payer data will transfer via the system to the next point of service, eliminating the need for re-registration.

On-line systems from such vendors as Scheduling.com, Atlanta-based McKesson-HBOC, and San Diego-based Healthline provide the initial capabilities of using the Internet to provide the front-end registration, verification, and scheduling functions. Other companies are working on improved solutions to develop a better system and means of communicating, registering, and scheduling in a more automated manner.

With interactive telecommunications and technology, the enterprise solution will not be limited to the hospital and its multiple departments, but will expand to a communitywide solution involving physicians, community health care services, organizations, help groups, and home services. This will create a truly integrated working solution for all health care partners involved in the service process.

The hospital's business environment will continue to change as a result of technology and system enhancements. Individuals will want to automate and improve operational efficiency as reduced revenues necessitate changes in the existing structure and service. Barriers will be eliminated, and silo operations will evolve into an integrated, supportive environment with everyone seeking a common goal — supporting the services of the hospital and supporting the physicians and patients in the community.

The right solution for every facility may not be a completely centralized model, but one that combines a degree of centralization along with a decentralized focus. Each hospital system must do a thorough evaluation to determine the best configuration — one that will be successful with physicians and patients and that will be a model for the future.

[Carol Miller's health care career spans 25 years and includes expertise in physician/hospital communications systems, telecommunications strategies, and hospital operations. She can be reached at (248) 386-8300 or at carol_miller@superiorconsultant.com.] ■

ACCESS FEEDBACK

Hospital gets a grip on MSPQ process

When a Medicare audit in the summer of 1999 found problems with the way Sarasota (FL) Memorial Hospital was handling the Medicare Secondary Payer Questionnaire (MSPQ), the hospital took immediate action, reports **Susan Evans**, CPAT, skills development manager for the patient registration department.

At one point, the hospital had more than $1 million a day in unbilled accounts, waiting for a completed MSPQ before they could be sent to Medicare, Evans says. As of February 2000, that figure had dropped dramatically and is now at about $50,000 per day, she adds, with an ultimate goal of zero.

APC solutions? Please call

Have you developed some effective ways to meet the challenges of ambulatory payment classification (APC) implementation? If so, **Beth Ingram**, CHAM, director of patient business services at Touro Infirmary in New Orleans, would like to hear from you.

"We are looking for a facility that considers its outpatient flow as related to APC implementation [a] best practice to make a site visit," says Ingram. "Specifically, we would like to visit a facility with both diagnostic and recurring outpatients in multiple entities, including medical/surgical clinics.

"Of particular interest," she adds, "would be a facility that employs a roving coder concept for recurring/clinic patients where the record remains in the clinic until the episode is complete. Additionally, we would be interested in facilities that use Medipac, from [Atlanta-based] McKesson-HBOC, as a patient registration/accounting system."

Ingram says she also would like to hear from any access managers who have established best-practice procedures for handling multiple encounters on the same day for different physicians that include both recurring and nonrecurring account types.

[If you have feedback on the APC issue, please contact Lila Moore at (520) 299-8730 or lilamoore@mindspring.com. Beth Ingram may be reached at (504) 897-8548 or ingramb@touro.com.] ■

No. 1 in the hospital's action plan, Evans says, was "a lot of education and repetitive training for registration staff." As departmental trainer — a job that had not been filled in recent years — she gives employees constant feedback on all registration errors, including problems with the MSPQ, she says. "When errors are made, we give the whole unbillable piece back to the people who made the mistakes. They have to call the patient at home [to get the missing information]."

In the past, Evans notes, the mistakes were handled at the back end by patient financial services.

Another key to the MSPQ improvement has been a dual software solution, she says. At the time of the Medicare audit, registrars were handling the MSPQ manually, she explains. "Before that, we had an automated system, but it gave the admitting representative the option of passing, and the data was questionable."

Now, with help from the information systems department, the hospital's homegrown admission / discharge / transfer system has been modified so an account can't be billed without an MSPQ, she says. A system called CareMedic completely screens every Medicare claim, looking for accident details that might indicate another payer is primary, Evans says.

Sarasota Memorial now has an annual training session for anyone who registers patients, as well as for all new employees, she says. Incomplete or incorrect accounts continue to go back to the person responsible on a daily basis. "It was very hard at first, but it worked," Evans adds. "What came out of it is that there are not as many errors. Before ending an account, [the registrar] thinks, 'Am I going to get this back tomorrow?'" ■

Insurer's Web site cures access blues

Work that's done in real time

Access managers throughout the country eventually may benefit from the innovation of a South Carolina insurance company that is making it easier for hospitals to submit claims, check eligibility, and obtain authorizations.

Blue Cross and Blue Shield of South Carolina, based in Columbia, now offers health care providers the ability to complete transactions with the insurer on-line, 24 hours a day, seven days a week, says **Terry Povey**, chairman of the company's Internet steering committee.

The company's goal in creating the Web site, SouthCarolinaBlues.com, Povey adds, was to allow medical providers and policy-holders to conduct their business transactions — beyond just enrolling and requesting identification cards, which some other insurers offer on-line — securely on-line and in real time.

The "My Insurance Manager" page on the site, he says, gives providers the ability to check the status of a patient's claim and / or eligibility, view benefit booklets, check inpatient and outpatient authorization, see how much a patient has paid toward the deductible and out-of-pocket amounts, and confirm whether the patient has any other health insurance.

A secure, "Ask Provider Services" transaction was added for any further questions, Povey says.

Internet program speeds eligibility check

Nearly half the population of Washington state — up to 3 million people — is expected to enjoy faster and more hassle-free health care, thanks to an Internet-based program being implemented by a group of several of the state's largest health care organizations.

The new program, created by members of the Washington Health Care Forum, allows physicians and hospitals across the state to devote more of their resources to patient care and less to unneeded administrative processing.

"The first of the four health plans has put patient eligibility on the system," says **Tom Curry**, executive director / CEO of the Washington State Medical Association and a Forum member. "Now, a question about who is eligible for service can be answered over a secure Web connection in just four seconds. That's four seconds — instead of making a phone call, getting a voice mail, making alternative command selections, being placed on hold, and other hit-and-miss procedures that often consume a lot of valuable time. The new system works just great and protects patient confidentiality."

All four participating health plans should be up and running on the eligibility portion before the end of this year, adds **Leo Greenawalt,** Washington State Hospital Association president. "The potential savings in time, money, and hassle are enormous. The patient benefits by getting better health service and lower costs. And this is just the first step."

As soon as eligibility verification is on-line at all four participating health plans, the next step is to create secure Web connections for authorizing referrals of patients to specialists and to assure prompt payment of claims to minimize patient frustration. Forum CEOs have assigned staff to simplify other administrative processes that now add time and take money away from patient care.

The Washington Health Care Forum is a group of leaders from health care provider organizations and health plans, including the Washington State Hospital Association, the Washington State Medical Association, First Choice Health Network, Group Health Cooperative of Puget Sound, Premera Blue Cross, and Regence Blue Shield. Work on developing the Web-based eligibility verification system began late last year, with the overall goal to make the health care system simpler and more efficient to navigate for consumers, physicians, and hospitals.

Representatives of the member organizations first met early in 1999 to set goals and develop a work plan, Greenawalt says. "All of us in health care need to remember that our fundamental goal is to provide good service to consumers with as little administrative hassle and as much care and compassion as we possibly can. Those of us who are members of the Washington Health Care Forum are taking action to make sure we deliver on that goal." ■

In addition, providers can go on-line to check one function, such as eligibility, for numerous patients or all functions for a single patient.

"We monitor the hits, or the utilization," he says. "What we are finding on a weekly basis is that when providers or members sign-on to "My Insurance Manager," only 3% of the time do they submit a question. That indicates that 97% of the time, they can find the information they seek on the site."

The company has a much higher opt-out rate with its voice response unit (VRU), Povey adds. "Sometimes it can run to almost 50%, where they get on the VRU and then have to opt out and talk to a customer service representative. We haven't yet researched to see if the VRU now gets fewer calls. Analyzing the call volume into our company and seeing if the Internet [option] has replaced that is the next step."

Since news of Blue Cross and Blue Shield of South Carolina's innovation got out, he says, many companies have called to find out how the insurer did it. They want to know how Blue Cross made the information secure and available on-line without using an Internet portal vendor and how it is making the information available in real time, Povey notes. A subsidiary of Blue Cross called Companion Information Management Resources, he adds, has a contract with the Blue Cross and Blue Shield Association to provide this service to Blues plans across the nation.

What is unique about the Web site, Povey says,

is that the technology used to create the "My Insurance Manager" pages is linked to the company's mainframe claims processing system, which provides the real-time capability. The site was designed with the user in mind, he adds, so providers and others accessing the site have their own pages and have the ability to interact on-line.

"This is new," he says. "We have not found any other health insurance companies nationwide that are offering this comprehensive a set of transactions. Claims status look-up is unique. We've gotten a lot of attention about this technology." ■

HIPAA transaction standards released

Goal is to simplify

The Department of Health and Human Services (HHS) has released its final rule setting standards for electronic transactions under the Health Insurance Portability and Accountability Act (HIPAA), but the jury is still out on whether those standards will help simplify the business of health care.

"For now, my attitude is one of 'wait and see,'" says **Peter A. Kraus**, CHAM, business analyst, patients accounts services, for Atlanta's Emory University Hospital. "Transaction standards are part of the HIPAA goal for administrative simplification. In principle, that sounds good and is long overdue. But pardon me for regarding government-directed administrative simplification as an oxymoron."

The rule, published in the *Federal Register* Aug. 17, 2000, can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. It will take effect roughly 60 days after its publication date.

The new standards establish the content and formats to be used in submitting claims electronically between providers and fiscal intermediaries. In a news release, HHS estimated the rule will create a net savings to the health care industry totaling $29.9 billion over 10 years.

Kraus says he has heard of "interesting" HIPAA security standards in the pipeline. "The word *simplification* was never mentioned once. Even with the best of intentions, the government, bless its bureaucratic soul, often causes more trouble than it solves. I don't know whether the transaction standards will be an exception."

The rule represents the first major block of HIPAA to be put in place in several months. Another key section implementing the 1996 act, dealing with privacy, should come out later this year. The electronic standards rule is being released under the assumption that the privacy protections will be in place at about the same time the transaction standards take effect, stated HHS Secretary Donna Shalala in the news release.

"If such privacy protections [are] not in place, HHS will seriously consider suspending or withdrawing the transaction regulation, pending appropriate privacy protections," the HHS news release reported. ■

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NEWS BRIEF

Hospitals hurting in spite of BBRA

Lowest margins since 1984

The Balanced Budget Refinement Act of 1999 (BBRA) has not quelled many of the financial problems facing the nation's hospitals, according to a recent study.

Despite the passage of the BBRA, America's hospitals continue to show declining hospital profit margins, according to an Ernst & Young LLP and HCIA-Sachs LLC study, "The Financial State of Hospitals: Post BBA and Post BBRA."

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

Smaller, rural hospitals are in the greatest financial jeopardy. By 2001, hospitals with fewer than 100 beds are estimated to report profit margins of less than 1%. 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 Lewin Group study.

"While the BBA has been successful in halting decay of the Medicare Trust Fund, which is now expected to remain solvent until 2023, the health care crisis has shifted to the financial condition of the nation's hospitals," said **John Morrow**, senior vice president of HCIA-Sachs. "Medicare payment reductions resulting from the BBA have caused a continued downturn in hospital financial visibility."

The impact of the reductions in Medicare payments attributable to the BBA has led to severe declines in hospital margin profits, according to **Michael Hamilton**, partner and national director of Ernst & Young's Health Care Advisory Business Services. "The modifications made to the BBA as a result of the BBRA have not forestalled declining profit margins, placing many community hospitals in financial peril." ■