



HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

INSIDE

■ **Computer-based patient records:** Standardization for clinical terminology 51

■ **Bed management:** E-board provides real-time picture of bed status 52

■ **DRG Coding Advisor:** Case managers deal with tracking DRG payments . . . 55

■ **Diversions:** Don't blame ED; look at 'life cycle of bed' . . . 59

■ **More bed solutions:** AM adds facilitator, improves ED communication 60

■ **Access creation:** Hiring managers crucial step for new department 60

■ **AM portfolio:** Clinical savvy will help your resume 62

■ **News briefs:** Number of critical access hospitals increases 64

APRIL 2002
VOL. 20, NO. 4
(pages 49-64)

Moving to electronic record-keeping system won't make legal issues vanish

Don't overlook potential legal conflicts

It's easy to assume that once a health care provider moves to a completely electronic medical record system, there will be major time efficiencies and improvements in record access that will help to improve clinical care, as well as coding.

However, what HIM professionals need to remember is that electronic records can create a variety of unique problems that might cause regulatory and confidentiality breaches.

"A lot of times, the people who are developing an electronic system have no background in health information management," says **Harry Rhodes**, MBA, RHIA, director of HIM products and services for the Chicago-based American Health Information Management Association (AHIMA). The people creating an electronic record system may not know about existing state and federal regulations governing how medical records should be established and maintained, Rhodes says.

"Information technology [IT] people know what the technology will do," Rhodes says. "But they may be totally ignorant of the health care environment and how it is different."

For example, from an IT perspective, it makes perfect sense to have a record that a person can re-enter and change as needed. This ensures that the record is up to date and prevents the time-consuming task of having to rewrite the entire set of background information that must be put in each record.

But when it comes to health care records, this type of efficiency will not work in the same way because there are legal rules of evidence that will not permit a medical record to be submitted as evidence if it has been altered or tampered with, Rhodes explains.

Likewise, it might make sense to permit a physician to sign an entire day's worth of documents with a single keystroke, but this also will not work in health care because regulations require physicians to sign each

NOW AVAILABLE ON-LINE: www.ahcpub.com/online.html
Call (800) 688-2421 for details.

document individually.

“So conflicts exist between what the technology will allow and the limitations on the records by laws and regulations,” Rhodes says. “Just because you can go in and delete files with a keystroke or back-sign 30 documents at once, that doesn’t mean the law will allow you to do this.”

When designing or revising an electronic record system, Rhodes says it’s a good idea to pay close attention to the following six areas:

1. Authentication.

This pertains to putting a signature on an electronic document.

“There are laws that tell you how things should be signed and that each document should be signed,” Rhodes says.

An electronic record system that is designed to satisfy a law that requires doctors to sign each document individually may have a cursor that the doctor will have to move from the top of the electronic page to the bottom before the doctor can sign.

Also, the system could make certain that only the doctor could sign by requiring a special password code that cannot be shared with anyone.

These types of requirements constrain the use of IT in health care record-keeping, because the technology makes it easy for a physician to sign 30 operative notes with one keystroke, Rhodes explains.

“But the state and federal regulations say, ‘No, the doctor has to go back to each of the 30 documents, read through each document, and sign at the bottom,’” Rhodes says. “That’s an accountability issue.”

Make arrangements for record storage

2. Retention.

“What you see happening now is that people are in a big hurry to develop an electronic medical record, and they don’t realize that state laws and federal regulations say they need to keep the document for six years,” Rhodes says.

As an electronic medical records system grows, it will require more record management, as well as long-term storage space with access information and an index for retrieving the information, Rhodes explains.

“As people define electronic medical records, they often don’t think about how with a traditional computer you can delete files and archives, but with medical files you must keep records for a certain length of time,” Rhodes adds.

3 Confidentiality.

Because so many different health care professionals may need access to health records, it is commonly assumed that the solution is to make the electronic medical record easily accessible.

“But now we’re facing HIPAA [Health Insurance Portability and Accountability Act] mandates to have access controls in place and minimum guidelines in place where people only can view records according to their jobs and roles,” Rhodes says.

This is a big difference from the way medical records currently are being accessed, and it could cause health providers problems with controlling access, especially when particular employees need to have access to certain parts of an electronic medical record, but not the entire document.

“There are no easy answers to the administrative burden, and some would call it an administrative nightmare,” Rhodes says.

4 Content requirements.

State licensure regulations, federal guidelines, and accreditation standards dictate what should be in medical records, so providers should carefully review these requirements before completing an electronic medical record.

“They may not realize that state law requires them to have a certain type of information in a certain fashion, and they go ahead with the record until they find out [through an audit] that they were supposed to capture this information and didn’t,” Rhodes says.

5. Amendment and correction.

Patients now have the right to correct their medical records when mistakes occur, and doctors may need to amend or correct data.

“Because this medical record is a legal document, you can’t have people going in and altering it,” Rhodes says. “Normally a document created someplace else and submitted as evidence is considered hearsay, so in order for the medical records to be exceptions to hearsay, they have to follow certain guidelines.”

For instance, the record must be made by the person with first-hand knowledge of the case, and the record must be protected from alteration or tampering, Rhodes says. Thus, clinicians cannot simply open an electronic file and delete and change information as they might with a normal word processor file.

The ASTM and Health Level 7 have guidelines for how to make a correction. For instance, the original document always should be saved unaltered in

the electronic record. Subsequent versions can be made and saved, but these will show a message that says where the original document is located, and the revised versions need to be identified as amendments or corrections. Also, these changes can only be made by the person who made the original entry.

“So there’s always a control to prevent the record from being altered or tampered with,” Rhodes says. “But a lot of times the people building the electronic system don’t build these controls into it when they’re creating it.”

Now with HIPAA, there’s the additional requirement that providers must permit patients to request an amendment or correction.

“If you refuse to allow them to make the changes, then the patient can still write a statement as an objection, and that goes into the record now, and the facility can write a rebuttal to the patient’s statement,” Rhodes explains.

For example, suppose a physician wrote in the original medical record that the patient is an alcoholic, but the patient objects to that description and requests that it be removed from the record. The physician would respond in writing that this cannot be done because the patient clinically had been diagnosed as an alcoholic. If the patient continues to object, the patient has the option of writing an objection statement that explains why the patient disagrees with the physician’s diagnosis, and this statement will be put in the medical record.

6. Patient control.

Under HIPAA privacy regulations, patients have a lot of control over the record and can restrict access to certain people, Rhodes says. “If it’s a reasonable request, you have to oblige them and place access restrictions on certain files that they do not want shared with certain people.”

Providers are required to give patients information about when the record has been released and who has had access to it. So all of these issues have to be designed into the computer application, Rhodes says.

“It will require you to do internal audits and see the names of everyone who has had access to records and what they’ve looked at,” Rhodes says. “You’ll need to know who the records were released to, and this information will need to be available for six years.”

The solution to reconciling regulatory requirements with the need for electronic medical records is for HIM professionals and others in the health

care field to be aware that health records are different from other types of records. There’s not one single authority to govern what can and cannot be done with the records. HIM professionals will need to look at state and federal regulations, as well as accreditation standards.

“When I worked in a facility, we decided to use an electronic signature, and we bought the office system and allowed the radiologist to back-sign all radiology reports,” Rhodes says. “We found out that state law wouldn’t allow that, and so we had to go to the manufacturer and ask for a revision so that we’d be in compliance with state law.”

These types of changes cost a great deal of time and money, so it’s a better policy to anticipate these issues before a system is either purchased or created, Rhodes recommends. ■

Standardization needed in CPR clinical terminology

Common definitions essential

The computerized patient record (CPR) is many things to many different health care professionals, and as the industry moves toward completely electronic health records, standardization is needed more than ever before.

“What’s happening in most health care facilities is they have grouper software systems that automatically group it to the DRG once they put codes and demographic information on patients,” says **Valerie Watzlaf**, PhD, RHIA, associate professor for the HIM department of the University of Pittsburgh.

“The whole purpose is if you just used ICD-9 codes, there would be so much of the content that people would want from the electronic health record that would not be there,” Watzlaf explains. “We’re looking at it in terms of getting data out to users, including physicians, nurses, researchers, HIM professionals, but it’s not necessarily linked to reimbursement.”

According to preliminary results of a recent nationwide survey conducted by Watzlaf and colleagues, more than one-third of responding health care facilities said they were planning to install a computer-based patient record.

“Twenty percent are saying they have a CPR

system fully in place, which is quite surprising,” Watzlaf says.

Most of those who have a CPR system appear to be using a vendor system, with less than one-fifth reporting that they have developed their own system in-house, Watzlaf says.

Among the most common clinical terminology for creating CPRs, besides ICD-9-CM and CPT-4, are the SNOMED, Read Codes, and Uniformed Medical Language System (UMLS). The UMLS serves as a medical thesaurus with clinical terminology, Watzlaf says.

“It seems in general that SNOMED in all categories is doing well, although researchers say that none of the systems available are effective,” Watzlaf adds.

For this reason, there are efforts under way to map SNOMED to the ICD-9 codes, so that the resulting system would be familiar to coders, Watzlaf says.

“SNOMED has always been a clinical terminology classification system used for coding diagnoses and procedures,” Watzlaf says. “I don’t know that anyone has used that for reimbursement, so it will be nice to enhance it to be mapped to ICD-9 codes.”

SNOMED began in 1965 as the Systematized Nomenclature of Pathology, an alphanumeric coding scheme. It was changed in 1977 to the Systematized Nomenclature of Human and Veterinary Medicine (SNOMED), which had an expanded alphanumeric coding scheme that included all terms related to diagnoses and procedures.

After several further evolutions, in 2000 it became the SNOMED Reference Terminology, which is a coded reference terminology implemented in the electronic health record, radiology, clinical lab, and surgical pathology. This year, the SNOMED Clinical Terms is under development, and includes the merger of the SNOMED RT with the Read Codes and a refinement of the mapping criteria to ICD-9-CM, Watzlaf says.

“In 1997, SNOMED had more than 150,000 terms that could be incorporated into database operations,” Watzlaf says. “One thing the ICD-9 does too is collapse codes into unspecified categories, and so a lot of times it’s thrown in there, and you lose the specificity with those types of codes.”

A chief advantage to SNOMED is that that it already collects more data than many other systems, Watzlaf adds. “If we want to move forward toward an electronic health record, we’ll need to be able to collect a lot more data, mine that data,

and look at extensive amounts of information.”

However, because the ICD-9 coding system is used so extensively in the United States, it’s important to have a CPR system that can be mapped to ICD-9 codes, and that’s where the latest version of SNOMED will be very helpful, Watzlaf says.

Besides creating a seamless transfer of data, an electronic health record should help improve clinical care, she notes.

For instance, a CPR will enable physicians typing in data about a patient to see text or pop-up boxes triggered by the particular data to remind the doctor to order a specific test, Watzlaf explains. “It all can be done very sophisticatedly with the CPR, and it’s not all that difficult to do.” All that is required is for the CPR system to have some type of terminology to break down the data and then a standardization like ASTM standards, she says.

“If we can organize data and standardize it across many different systems within different health care facilities, then we have a longitudinal health record that could be very similar across facilities, and it will be more standardized to clinical content,” Watzlaf says. ■

IS provides real-time bed management system

Going ‘three steps beyond’ initial ideas

A new bed management system in place at Aurora Health Care’s Milwaukee-based hospitals is eliminating the need for daily meetings, saving untold numbers of phone calls, and “doing things we never even anticipated,” says **Marne Bonomo**, PhD, regional director for patient access.

The Oracle database, built by Aurora’s information systems (IS) staff, is interfaced with the admission-discharge-transfer (ADT) system and provides real-time bed management capability, she adds. When patient volume is high, Bonomo says, “I can do a printout of the [bed status] summary and walk around with a piece of paper telling me the latest status of the hospital. No computerized bed management system I have worked with has even come close to this one. Every time we get in a room to discuss functionality, we think of something else that it can do.”

No longer necessary, she says, are the daily 11 a.m. calls by nursing staff to get the status of the facility's beds, and the daily 11:30 a.m. meeting with the charge nurse and bed placement staff to determine afternoon staffing. Instead, those involved simply can access an "e-board" on their computers to instantly see which beds are empty, which beds are occupied, and who is in them. Housekeeping can see which rooms need cleaning.

With the new system, Bonomo says, she no longer needs to scroll through computer screens or have a patient's name to check the status of a particular bed. "I can hover the computer mouse over a particular cell and see who's in that bed, or I can see a picture of the whole hospital on one screen, which is amazing."

Bonomo credits what she calls an incredible IS team for the success of the bed management system. "Every idea we've given them, they've taken three steps beyond," she says. "I think they have telepathy." Hours spent in programming, she notes, are the only real expense associated with the new system.

For admitting staff not actively managing beds, the system's benefit is that it will show "the reality of the beds," Bonomo points out. "Once we start putting in pending patients — those waiting for a bed — it gives us a higher level of knowledge. We now have the ability to predict within a 5% variance how many patients to expect on any given day. We are using calculations based upon history, what we know is scheduled for today, what is pending from the ED [emergency department], and factoring in the number of current patients that have discharge orders."

A spotlight color system immediately informs staff of the hospital's occupancy level, she says. "With a green light, we can take anything; with yellow we're beginning to get full; and with orange, we are triaging admits and working very closely with the ED because we are down to 12 beds, of which only three are critical care."

When the status gets to red — or diversion — level, Bonomo adds, "We have nothing." The spotlight colors come on automatically, she notes. "The point of that is to alert the ancillary support departments. Housekeeping knows to go into the high-census plan and can approve overtime and extra shifts without going to regional management."

Aurora went live with the database in January at its largest hospital, St. Luke's Medical Center,

and at the hospital's second campus, St. Luke's South Shore, Bonomo notes. "The next two largest [facilities] are clamoring to go up."

It will not be long, she says, before the other Aurora hospitals are on board. "The executive vice president of nursing is very interested in having the same information from everywhere else that she now has from St. Luke's."

A true picture

The system actually was put up in late December 2001, but staff realized some more tweaking was needed. "When you asked for a private room, for example, all of the critical care-beds popped up, so we qualified some of the searches," she says.

Once the database is in place across the 13-hospital system, Bonomo points out, personnel handling patient transfers can look at Aurora facilities across the state and see "where things are busy, and where they're not, and where we can be more efficient."

This capability will eliminate multiple phone calls to bed placement staff regarding patient transfers, she says, as well as quell any skepticism about the number of beds actually available. "Now everybody has a picture of what is true."

With the confidentiality guidelines of the Health Insurance Portability and Accountability Act (HIPAA) in mind, Aurora has taken steps to ensure proper management of the e-portal that allows access to the bed management database, Bonomo says. Aurora's e-portal already is HIPAA-compliant, she adds, and the organization is moving toward an intranet strategy to reduce the need for additional outside vendors, part of a corporate strategic goal.

Five different access levels were created, Bonomo says, including levels for patient placement, housekeeping, patient care management, and ancillary departments, which only need to see how full the units are. An administrative level allows more in-depth access for system management and setting up access privileges, she explains.

"Those who have access can dial in from any PC anywhere," Bonomo says. "At first, we only had three levels of access for the e-board, but then we decided we needed more. The housekeeping staff didn't need to know who was in that bed, so their access allows them only to see all the beds and to know to change them from

dirty to clean. Patient care management needs to know who's in the bed, but shouldn't be changing any of the information."

At the administrative level, very few people can make changes to the database and change the level of those who access it, she notes. "There's a detailed level for the placement staff so they can change the status of virtually any room or equipment, but can't change the board itself or give other people access."

The planning for the bed management system is being done by an administrative team that includes the head of the hospital, key physician leaders, and the director of nursing, in addition to Bonomo. That team is busy developing policies and protocols, she adds, with strong support from a quality management representative. That person provides the team with statistical analyses and is instrumental in disseminating information such as average discharge time and diversion rate. The quality management rep also worked with the statisticians to develop the historical reports that are used for evidence-based predictions, she adds.

John Whitcomb, MD, the hospital's medical director of emergency services, has been instrumental in garnering support for what needed to be done, she says. "He has been our advocate with every medical service and every medical leader, taking the time to present this new philosophy to countless medical sections and quality leadership meetings." Historically, Bonomo notes, all the hospital diversion activity was blamed on the ED, when the real problem was a lack of information and of coordinated effort across the facility.

'Just keep it about the data'

Whitcomb points out that hospitals with diversion problems need to address what he calls the "life cycle of a bed," looking at elements that are precise and that can be measured. **(See "With diversions, ED is just a symptom of inefficiency," p. 59.)** Some physicians tend to focus on the fact that "they have medical judgment and you don't," he cautions. "Don't get into that with them — just keep it about the [data]."

Some physicians are still trying to do things "the old way," Bonomo says, by calling the nursing units directly to place their patients. "The policy now is that all patients are placed through patient access." However, when a physician calls the unit, the nurse typically will take the information and simply get the access department on

another line without making an issue of it, Bonomo adds.

Meanwhile, she says, "the confidence level [among physicians and others] is building. We are installing monitors in key physician lounges that display the summary screen. It's set up to show the beds that are functional, those that are blocked, and the percentage of occupancy. Those who are savvy enough can go looking through [the system] to get more detail, such as how many patients are on telemetry."

Sheraton hotel system provides model

Aurora's initial idea for the Oracle database and the leadership team came from Vanderbilt University Medical Center in Nashville, TN, Bonomo notes. "I had read a white paper presented to the American College of Health Care Executives by Barbara Walczyk, Vanderbilt's director of performance management and improvement, outlining how they significantly reduced diversions with their bed management initiative. They developed a database based on the Sheraton hotel system and new procedures initially that reduced their diversion rate something like 96%."

Vanderbilt personnel were asked to come to Aurora in August and present their project, she says. From that initial inservice, Bonomo adds, a healthy competitive partnership was born, with information and wins shared for mutual benefit.

While Vanderbilt's bed management database was not integrated with its ADT system, she says, Aurora's now has that functionality. "We even have the ability to integrate our e-board with any ADT system. This was almost too good to be true."

Aurora has a homegrown system called ADZ across several hospitals. It uses a product from Atlanta-based McKesson-HBOC at one hospital, and is in the process of migrating systemwide to software from Kansas City, MO-based Cerner Corp.

"With our system," Bonomo points out, "wherever the patient is seen first, it shows up on the e-board. I can fly over a cell, see who is in a bed, the diagnosis, the physician, and the patient's date of birth, because this information is in the registration system."

However, she adds, "we would never have gotten started had we not seen the information from Vanderbilt. We knew that predictive management was possible, but the difficult part was where to begin. Vanderbilt opened that door for us." ■

DRG CODING ADVISOR.

Tracking excessive DRG payments falls on case managers

OIG estimates \$52.3 million in overpayments

Hospital case managers responsible for discharging patients to post-acute settings should take note that many of these discharges violate the new transfer rules that went into effect two years ago. In fact, the Health and Human Services Office of Inspector General (OIG) estimates that Medicare paid approximately \$52.3 million nationwide in excessive DRG payments to prospective payment system (PPS) hospitals as a result of erroneously coded discharges.

"In most hospitals, case managers are responsible for documenting the discharge planning arrangements," says **Deborah Hale**, president of Administrative Consulting Services in Shawnee, OK. "That is what the coder uses to assign the disposition code."

In the final rule, the Centers for Medicare and Medicaid Services (CMS) indicated that hospitals maintain their responsibility to code the discharge based on the discharge plan for the patient. If the hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill. However, the agency acknowledged that hospitals will not always know the disposition of patients.

"It is a crazy system, and it puts the hospital in a difficult position," Hale says. That is because hospitals often lack the resources to track patients once they are discharged. If case managers do their job well in planning for discharge by looking at all the options and knowing what all the possibilities are, that is about as much as they can do, she says.

According to the OIG, CMS has no controls in place to prevent excessive payments to PPS hospitals for erroneously coded patient discharges that are followed by post-acute care, such as care in a

skilled nursing facility or a home health agency. There were more than 1 million discharges between Oct. 1, 1998, and Sept. 10, 1999, within the 10 specified DRGs. Of these discharges, 14,890 claims were followed by post-acute care treatment that fell within the window of time necessary to categorize the discharge as a qualified discharge/post-acute care transfer and met all of the criteria necessary to result in a potential overpayment, the OIG said.

Medicare payment rules provide that, in a transfer situation, payment is made to the final discharging hospital, and each transferring hospital is paid a per-diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

As of Oct. 1, 1998, a discharge from a PPS hospital with one of the 10 specified DRGs to a post-acute care setting is treated as a transfer case. The applicable post-acute care settings include: a hospital or hospital unit that is not reimbursed under PPS, a skilled nursing facility, or home if there is a written plan of care for the provision of home health services and the services begin within three days of the discharge.

Reimbursement for qualified discharges is made under one of two payment methods, each of which is designed to match the reimbursement more closely to the hospital's cost of providing care to the patient. In the event that the cost of providing care to a patient meets the criteria to be deemed an outlier, additional payment is allowed for the qualified discharges.

For DRGs 014, 113, 236, 263, 264, 429, and 483, hospitals are reimbursed at a graduated per-diem rate for each day of the beneficiary's stay. Under this calculation, the full DRG payment amount is divided by the mean length of stay for the specific

DRG to which the case is assigned. Twice the per-diem amount is paid for the first day, and the per-diem rate is paid for each of the remaining days, not to exceed the full DRG payment.

For DRGs 209, 210, and 211, reimbursement is calculated differently. On day one of a postacute transfer, hospitals receive one-half the DRG payment amount plus the per-diem payment for the DRG. For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment.

In addition to recovery of overpayments, the OIG recommends that CMS establish edits in its Common Working File to compare beneficiary inpatient claims potentially subject to the post-acute care policy with subsequent claims. The agency says this will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim. CMS officials concurred with these findings and recommendations. ■

Coding consistency should be HIM focus, AHIMA says

Health care providers should follow the same rules

One of the biggest challenges facing the medical coding industry is making medical code sets consistent with rules and conventions that are followed by all health care providers.

"Payer-specific guidelines are not consistent with nationally recognized guidelines, and we want everyone to operate off the same set of guidelines," says **Susan N. Postal**, MBA, RHIA, vice president for health information management services for HCA of Nashville, TN. Postal is the 2002 chair of the Coding Policy and Strategy Committee of the American Health Information Management Association (AHIMA) of Chicago.

The current problem results from a clash between why coding classification systems were developed and how they are being used, Postal explains.

"Coding has become one of the components for how reimbursement is determined, and that's what led to some of the confusion," Postal says. "As coding was used years and years ago, it was for statistical purposes and data purposes; now it's also used to reimburse providers."

Another factor is that providers can't use coding systems consistently within their own organizations because, depending on payers, there may be different guidelines, Postal says.

AHIMA recommends that all payers and providers be required to adhere to existing code set rules, definitions, and guidelines. In recent testimony to the National Committee on Vital and Health Statistics Standards and Security subcommittee, **Sue Prophet**, AHIMA director of coding policy and compliance, outlined the problems with current coding sets.

"ICD-9-CM lacks sufficient clinical detail to describe the severity or complexity of diagnoses, and does not provide sufficient codes for health-care encounters for reasons other than treatment of disease, such as preventive medicine or after-care," Prophet told the committee on Feb. 6.

Prophet explained that the ICD-9-CM is more than 20 years old and has become outdated and obsolete because its classification of some conditions is inconsistent with current medical knowledge.

Likewise, the CPT system has major flaws. "Many CPT codes are imprecise and ambiguous, failing to provide the desired level of specificity and detail regarding the service performed," Prophet told the subcommittee.

Each coding system currently used has problems, and the solution is to require uniformity and consistency of all health care organizations, payers, and other data users, Prophet said. **(See story about AHIMA's coding recommendations, p. 57.)**

"To achieve accurate and complete coded data and health information that supports this country's health care services, research, and so forth, health care providers, health plans, and other organizations must uniformly subscribe to the same coding guidelines and practices, regardless of the level or site of healthcare service, or the method of reimbursement," Prophet told the NCVHS.

AHIMA seeks to take a leadership role in working with the government and other groups to develop standards and guidelines, Postal says.

"I think that people are committed to doing the right things the right way, and people need consistent guidelines and consistent direction," she says.

"The technology and industry are advancing, the payment systems are becoming more complex, and the classification systems need to be updated," Postal adds. "So we need to move to one procedural classification system." ■

AHIMA recommends coding policy change to Congress

Goal is guideline consistency

The American Health Information Management Association (AHIMA) of Chicago recently presented its concerns, observations, and suggestions about medical coding systems to the National Committee on Vital and Health Statistics Standards and Security subcommittee. **Sue Prophet**, director of coding policy and compliance for AHIMA, outlined the following recommendations during her recent testimony:

- All payers and providers should be required to adhere to the existing code-set rules, definitions, and guidelines as developed by the code-set maintenance organization and published as part of the code set. HIPAA (Health Insurance Portability and Accountability Act) regulations should be modified to require that users or covered entities follow a code set's rules, definitions, and guidelines in line with our other recommendations.

- Coding guidelines should be part of the standard code set so that all users must abide by them. HIPAA regulations should be modified to reflect this requirement. The coding system rules and guidelines should be updated on the same schedule as the code set.

- Every accepted standard medical data code-set organization must be required to have an organized process for the development and maintenance of the codes and rules and guidelines for the correct, consistent use of their code set. The process for developing codes, code-set rules, and guidelines for proper use of the medical code sets should include broad access and input and approval representation from a range of stakeholders, including coding and clinical experts, practitioners, and users. Input should be solicited prior to finalization of a new or significantly revised rule or guideline and meetings should be open to the public or at a minimum to the stakeholders. Notice of meetings should be posted at an appropriate time in at least the *Federal Register*, and the agenda and information on submitting items for the agenda should be posted in a suitable manner.

- All these processes should be placed under the supervision or oversight of a single entity or authority. Such an entity should provide oversight

and authority to the guideline development process for each medical code set, ensure consistency in processes, and ensure that the various standard code sets complement one another and work in tandem without duplication or overlap. To this degree, such an authority would act much as the American National Standards Institute does with its various standards groups. Such centralization exists in most other countries.

AHIMA also made the following recommendations for improvement of medical coding:

- A single procedural coding system should be developed and adopted for use across all sites of health care services.

- There should be a federally funded examination on the feasibility of moving to a single system that examines:

- The efficacy of alternative systems across all health care settings, for all payer types, and all types of health care services. It should also address the need for uniform data to fulfill the needs of a national health care and public health infrastructure, health care research, other non-treatment use of health care data.

- The implementation and long-term cost and benefits of a single system compared to that of operating multiple systems.

- A recommended strategy for implementation that takes into account the need to implement ICD-10-CM.

- The Healthcare Common Procedure Coding System (HCPCS) should be revised to recognize the single procedural coding system as the only coding system to be used for procedures and services. HCPCS should then become a coding system, with a more open development and maintenance process, representing only the products, technology, and supplies that are not procedures and services. ■

OIG sounds alarm on transfer coding errors

Correct use of PPS transfer policy will help

Numerous hospitals continue to incorrectly report prospective payment system (PPS) transfers as discharges, and that has translated into potential overpayments of nearly \$233 million, warns the Department of Health and Human Services Office of Inspector General

(OIG). Since 1992, the number of incorrectly reported transfers has trended downward, the OIG says.

According to the OIG, the primary reasons for this ongoing problem include the misapplication of the PPS transfer policy by the Centers for Medicare and Medicaid Services regional offices and the fiscal intermediaries, problems with computer system interfaces at hospitals, and breakdowns in communication between hospitals' medical and billing staffs.

The last of those areas, and perhaps the most significant, is where case managers come in, says **Beverly Cunningham**, MS, RN, director of case management at Medical City Dallas Hospital.

"This is a big issue, because sometimes it is very difficult to find in the chart exactly where the patient went," she asserts.

It is also an area that can save hospitals a tremendous amount of money if done correctly, she adds.

According to the OIG, hospitals incorrectly reported an average of 1,132 PPS transfers per month in 1992.

That number declined to about 495 per month in 1999. All together, the agency says it identified more than 153,000 claims for incorrectly reported transfers during the period January 1992 through June 2000. Hospitals provided three primary reasons why they had incorrectly reported PPS transfers as discharges. The first was problems in interfaces within hospital computer systems, most notably between medical records and billing components, which led to the submission of claims as discharges rather than transfers.

The second problem area dealt with assumptions that the receiving hospital is excluded from PPS based on the type of patients accepted and services rendered. According to the OIG, hospitals often reported transfers to long-term care hospitals using discharge code 05 (discharged/transferred to another type of institution) without confirming that the receiving hospital was, in fact, excluded from PPS.

The third area involved breakdowns in communication between hospitals' medical and billing staffs. The OIG reports that, in some cases, the hospital's rate of incorrectly reported PPS transfers declined significantly or ceased after internal reviews detected the problem and steps were instituted to prevent the incorrect reporting of PPS transfers.

On the other hand, the OIG reports that none of the hospitals that detected problems had taken

steps to determine the significance of the problem and repay Medicare for the overpayments received.

One of the implications here for case managers is that there must be a clear discharge plan that is documented on the chart, Cunningham says.

"That goes hand in hand with the Joint Commission's new standard that says hospitals will provide timely discharge planning for their patients that includes the patient and their family," she adds.

"If medical records looks at a chart and is unable to determine if a patient is going to home health or if they fall under one of the transfer DRGs, then somewhere we have missed the boat in providing a clear discharge plan on the chart," she explains.

Case managers should not necessarily assume all of the responsibility in this area, Cunningham says. But she says it does point out the importance of case managers working closely with nursing.

"There are going to be patients who get discharged after hours unexpectedly," she warns. "It behooves all of us to figure out a way that we can be very clear in that discharge plan." ■

AHC Online

Your One-Stop Resource on the Web

More than 60 titles available.
Visit our web site for a complete listing.

1. Point your web browser to:
www.ahcpub.com/online.html
2. Select the link for "AHC Online's Homepage."
3. Click on "Sign On" on the left side of the screen.
4. Click on "Register now!" (It costs nothing to register!)
5. Create your own user name and password.
6. Sign on.
7. Click on "Search AHC" on the left side of the screen.
8. Perform a search and view the results.

If you have a subscription to a product, the price next to the search results for that product will say "Paid." Otherwise, the pay-per-view cost per article is displayed. To see a sample article, click on "Browse Issues" on the left side of the screen. Select *Clinical Cardiology Alert*, 1997, January 1, and the first article, "More Good News About Beta Blockers." We've made this article free so you can see some sample content. You can read it on-line or print it out.

Test Drive AHC Online Today!

With diversions, ED is just a symptom of inefficiency

Check bed life cycle, physician says

Although the emergency department (ED) is a popular scapegoat when it comes time to assign blame for hospital diversions, it is just the symptom of an inefficient hospital, says **John Whitcomb**, MD, medical director of emergency services for St. Luke's Medical Center in Milwaukee.

That inefficiency is defined by several clinical processes, "all of which are slow," Whitcomb adds, who helped spur development of a cutting-edge bed management system at Aurora Health Care. "They all happen at the same time in the middle of the day, and they all have in common one person occupying two beds or a bed with nobody in it."

Those problematic processes, he says, include the following:

- **Discharge from the hospital.**

From the time the physician writes the discharge order until the bed is reoccupied, says Whitcomb, is in the range of six to eight hours. He says the patient is there for the first two or three hours, and then there are multiple hand-offs — to nursing, to pharmacy, to transport the patient. Each one is just 15 minutes, but when there are 10 of them, suddenly that's six hours.

- **Transfers between units in the hospital.**

When a patient is transferred from the intensive care unit (ICU) to the nursing floor, he or she is in one bed and waiting for the other, he notes. The other bed has to be cleaned, and the order has to be given and coordinated with pharmacy. Then the patient, along with personal effects, has to be moved, and the family directed to a different waiting room. Again, according to Whitcomb, it's about a six-hour process.

- **Procedures in the operating room (OR).**

While an elderly or frail patient is in the OR for a five-hour procedure, "his slippers and robe are in the original room," Whitcomb points out. "He may go back there, or he may go to a room in the ICU, which is on hold because the patient is so frail." Both beds are held in reserve until the outcome is clear.

- **Outpatient procedures.**

There's a similar process with outpatient procedures, whereby physicians hold open the option of

admitting a patient to the hospital, just in case there are complications or unforeseen outcomes. "In the meantime, there are all these other procedures where a bed is put in reserve, and all of those procedures peak in the middle of the day," he says.

That means that in the middle of the day, he explains, any hospital with an occupancy rate of more than 80% thinks it's at 120%. "It's because [clinicians] have saved a bed, 'just in case.' It's that 'just in case' stuff that's causing the problem."

At noon, Whitcomb says, hospital personnel likely are to get so panicked by these numbers that they send business elsewhere, only to find there are 20 available beds at 8 p.m.

'Private deals' cause confusion

"That's because they didn't know how many beds they had, really," he says. It doesn't help that various physicians are calling the units directly to make private deals to get their patients admitted, Whitcomb says.

"It's a confusing process," he says. "You can't keep track and you don't have control of how long it takes for one empty bed to get reoccupied. So how can you make a science of that?"

To correct what Whitcomb calls "the life cycle of a bed," there is certain hard information that can be measured, he says. Terms that need to be clearly defined, include the following:

- **Available bed.**

"This is not a licensed bed, not a budgeted bed, and not a bed with sheets on it," he says. "It's a staffed bed. Access people need to recognize that the hospital they're working with is not the same every day. Every day it's a little different. Patients are complicated. Some patients have one nurse, and in another place, one nurse is caring for five patients."

- **Open bed.**

An open bed, Whitcomb says, is a bed for which a discharge order has been written. When the order's written, the clock begins ticking, he adds. "When is the secretary going to report it? When is the patient going to be moved out? When is it going to be cleaned? When is a new patient assigned to it? When is a report given from the incoming patient? When is the patient actually in the bed?"

If it generally takes six hours after the order is written for a bed to be open, Whitcomb notes, what would be the benefit if that time were cut in half? "If you can add three hours of occupancy,

and the average hospital stay is five days, you gain 3%,” he says. “With a 500-bed hospital, you’ve gained three empty beds. Once the situation is defined, you can put a tool together to manage it, and you can act prospectively. Then you can make what you do match the hospital’s mission.” ■

Access department takes action to avoid bed crunch

Communication with the ED is key

Like many hospitals, Philadelphia’s Presbyterian Medical Center actively is engaged in the challenges of bed management, particularly with the cold-and-flu season putting an extra strain on resources, says **Anthony M. Bruno**, MPA, MEd, director of patient access and business operations.

“This is our busy season, and we are in the same boat as many others who don’t have enough nurses to manage all of our beds all of the time,” he says. “Some of the beds are closed because there are not enough nurses to provide the care.”

To help ease the bed crunch, Bruno says, his department is involved in three specific initiatives.

- **Hiring an admissions nurse facilitator.**

“That person’s job will be to manage the beds on a day-to-day basis, Monday through Friday,” he explains. “She will work closely with physicians, nurses, the emergency department [ED], the catheterization lab, in an effort to coordinate the use of beds and the placement of patients.”

This new “bed czar,” Bruno notes, will report to the manager for admissions and to one of the hospital’s directors of nursing. “We’ll have a clinically trained professional up in the nursing units, directing and coordinating admissions and discharges.”

- **Working with the ED to improve communications.**

In late January, he says, patient access staff began giving confirmation numbers — like those used by hotels — to ED personnel any time they call in for an admission. “This is so there will be no question as to whether or not they called us, and whether or not we received the information that a patient is coming from the ED,” Bruno adds.

“Sometimes [ED personnel] will say, ‘I called in the bed an hour ago,’ when they really didn’t,” he

says. The department also will be keeping more stringent logs to go along with those confirmation numbers, Bruno notes.

- **Placing discharge reminder cards in patients’ rooms.**

Tent cards, such as those restaurants put on tables to advertise specials, will be used to encourage patients to begin preparing for discharge as soon as they arrive, he says. The information on the card starts out with the phrase, “We know you’ve just arrived, but soon you will be homeward bound.” It emphasizes — with words in bold type and again in a list of suggestions — that patients should make plans to have someone pick them up before 11 a.m. on the day of discharge.

The following suggestions also are made:

- Ask your doctor or nurse about diet, exercise, prescriptions, and when to see the doctor after you go home.

- Arrange to have flowers and personal items you won’t need overnight sent home.

- Arrange for someone to be at home when you arrive, if you’ll need help.

“Late discharges are always a problem,” Bruno notes. “We used these [tent cards] at a couple of other hospitals where I worked and they were very well received by patients. They didn’t cure everything, but what we’re trying to do is use a multifaceted approach, to come up with a number of things that will all help amend a bed crunch.” ■

Successful recruiting is key to access creation

Goals, objectives viewed weekly

One of the first milestones **Anthony M. Bruno**, MPA, MEd, reached in his mission to create a brand-new department of patient access and business operations at Philadelphia’s Presbyterian Medical Center was the successful recruitment and hiring of four managers.

Those individuals — along with the existing manager of business operations — will help carry out the process of taking previously decentralized departments and putting together a centralized operation of business activities, says Bruno, who is giving *Hospital Payment & Information Management* periodic updates as he works to

establish the new department. He became director of patient access and business operations in July 2001.

Newly created positions that were filled include the manager for outpatient access services, the manager for quality assurance and training, and the manager of the admissions center, he says. An existing position that Bruno filled is manager for emergency department access services.

These employees collectively have more than 100 years of patient access experience and more than 50 years of experience with the University of Pennsylvania Health System (UPHS), Bruno notes.

Employees: Most valuable asset

“I started off by sharing my management philosophy and management goals and objectives with the team,” he says. “The direction in which we’re heading and will spend the most time with is working with our most valuable asset, our employees. You can’t do the job without employees.”

Current operational goals and objectives include:

- establishing a cash collection program;
- setting up bedside registration in the emergency department;
- accomplishing all “Code Green Workplan” objectives.

“Code Green,” he explains, is a UPHS project — begun in 1999 — designed to improve management of the revenue cycle and increase profitability. His department’s piece of that includes reducing registration errors, billing rejections, and denials. On the front end, he says, the goal is to enhance the department’s collaboration with medical records, utilization management, and patient accounts, all of which directly impact its ability to manage rejections, denials, and the revenue cycle.

“To do any of these things, you need to have a staff that’s well educated and well trained,” Bruno says. “We’re starting with a plan that centers everything around a management report — which is the way I like to work — that we work on weekly.”

The report includes the department’s goals and objectives for the fiscal year, with a listing by each manager — including Bruno — of the activities with which they are furthering those objectives. “We give a status update of each of those on a weekly basis in order to communicate and

make sure we are focused on what needs to be done,” he says.

In line with his staff-centered approach, Bruno says he also is rewriting the job descriptions for all employees to make sure each description accurately reflects the desired duties and responsibilities for each registrar. Customer service skills, for example, will be a key part of those descriptions.

“We’ve pulled the team together, and now we’re focused on organizing,” Bruno says. “We need to make very clear to everyone what our expectations are and what their responsibilities are. You can’t ask people to do something if they don’t know exactly what you want them to do. I think it needs to be in writing.”

This facilitates the process of giving feedback to employees, of maintaining quality assurance, and of doing staff training, he notes.

‘A shared-value environment’

One of the things he emphasizes is “a shared-value environment.” “Basically, that means developing role understanding and a shared vocabulary so you know what you’re talking about, with projects as well as insurance requirements,” Bruno says. “It also involves strengthening trust among employees, letting them know the management team is there to work with them, not just giving instructions and walking away.”

A key to fostering such an environment, he says, is promoting delegation and empowerment, having a staff who are empowered to do tasks when managers are not present.

“We define protocols and codes of behavior that we expect,” he explains. “That can be something as simple as dress codes, which should be spelled out.”

A behavior that is paramount, he says, is “a certain attitude toward patients, to be willing to reach out and assist patients no matter what they’re asking for.”

Helping to define and promote the shared-value environment is a 24-page handbook on employee duties and responsibilities, Bruno says. It includes a mission statement, a confidentiality policy, orientation and probation information, a list of patient rights and responsibilities, a dress code and appearance policy, and a customer service policy, he notes. There also are guidelines regarding departmental safety, attendance and time records, work performance expectations and

evaluations, Bruno adds, as well as information on clinical effectiveness and quality improvement programs.

“There’s another section called Thoughts Worth Remembering,” he says, which addresses such subjects as proper attitude and telephone etiquette. “We also gave out something called ‘The Measuring Stick,’ a document circulated among the business community that talks about testing the strength of the workplace. There are 12 questions that ask you about work situation. By answering them, you describe the situation you have.” (See “**The Measuring Stick**,” below.)

Now that he’s gotten together a staff with the

necessary skills and experience to do the job, Bruno says he is trying to focus on building this department. “We’re just in the process of beginning to exist. The people are all new to each other. We’re trying to get our objectives across for this year and start to carry them out.”

So far, so good, he notes. “I will say that since I’ve been here, we’ve been through a successful JCAHO [Joint Commission on the Accreditation of Healthcare Organizations] survey and Pennsylvania Department of Health survey.” ■

The Measuring Stick

The questions listed below don’t capture everything you may want to know about your workplace, but they do capture the most information and the most important information about your workplace. They measure the core elements needed to attract, focus, and keep the most talented employees. Here they are:

- Do I know what is expected of me at work?
- Do I have the materials and equipment I need to do my work right?
- At work, do I have the opportunity to do what I do best every day?
- In the last seven days, have I received recognition or praise for doing good work?
- Does my supervisor or someone at work seem to care about me as a person?
- Is there someone at work who encourages my development?
- At work, do my opinions seem to count?
- Does the mission/purpose of my health system make me feel my job is important?
- Are my co-workers committed to doing quality work?
- Do I have a best friend at work?
- In the last six months, has someone at work talked to me about my progress?
- This last year, have I had opportunities at work to learn and grow?

Source: Presbyterian Medical Center, Philadelphia.

Keep up-to-date portfolio that includes clinical skills

AM nurses have advantage

Access managers continually need to refine the contents of their career portfolios to rise to the challenges of today’s health care environment.

That’s the suggestion of **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management (IRM) in Carlsbad, CA. Access managers typically are better suited than their counterparts in the business office, for example, to play a pivotal role in addressing the clinical issues associated with denial management, Duffy says.

In many facilities, he notes, the chargemaster — the primary document for charging all the services, supplies and pharmaceuticals in a hospital — either is decentralized to ancillary departments where staff don’t have the necessary training or centralized in the business office. The person who oversees it in the business office, Duffy says, is likely to know something about billing, but little about clinical issues.

“The chargemaster turns out to be a clinical document,” he says. “To keep these critical items up to date, you need individuals who have nomenclature and disease process experience. It’s more likely that an access manager rather than a business office manager would have this in his or her background.”

COMING IN FUTURE MONTHS

■ HIM industry leaders discuss concerns

■ Proposed diagnosis code modifications for ICD-9-CM

■ Training staff for privacy rule requires good strategy

■ The latest on preparing for HIPAA

■ What’s the benchmark for patient identification?

The growing number of nurses who are access managers, Duffy suggests, “would make wonderful partners to central supply or in making improvements to the chargemaster, where the errors can reach 90%.” Access managers can add to their professional stature, he says, if they can perform that role.

“Because of the nature of changing supplies, and the bombardment of ambulatory payment classifications (APCs), the average hospital has 100 changes a week,” he adds. “If those are not done on a timely basis, and the contracts are not understood, the consequences of miscoding the chargemaster could be financially devastating.

“[The chargemaster] needs constant review. I’ve seen hospitals that have undercollected up to 40% because of errors in the chargemaster, inability to code, and lack of ability to present complex issues on a bill.

In organizations that moved to the central business office (CBO) model, most of those CBOs now are off-site and serve geographically diverse areas. Because the business office has left the [hospital] arena, Duffy says, the gap between those professionals has widened.

In such cases, the access manager may be “the No. 1 person on campus” when it comes to revenue management. “This is a risk as well as an opportunity for that on-campus access manager to take on the role of developing revenue,” he says.

The real question, he suggests, is whether the access manager portfolio represents success from point-of-service inception to bill drop. If the answer is yes, Duffy says, then you need to examine all of the skills necessary to do that successfully.

For the access portfolio to really be comprehensive, those skills should include:

- working knowledge of call center operations;
- understanding of charge capture;
- eligibility and authorization expertise;
- innovative ideas about point-of-service collection;
- successful management of the chargemaster.

“The gap between what happens at registration and the bill drop is huge,” Duffy says. “What happens before billing is a whole management area that is a no-man’s land. I don’t see a named executive who really understands the consequences of doing this right.”

Much of the gap, he suggests, is because registration departments still have the habit of being shift-oriented. “Some [hospitals] don’t return anything to registration for rework, and

some return a lot, but build huge inventories, and send incomplete [bills]. The access department has to delete the thought process that completing the shift is the end of its responsibility.”

Access managers should become familiar, Duffy says, with initiatives such as the Patient-Friendly Billing Project of the Healthcare Financial Management Association and the American Hospital Association. This effort, he says, is centered on revamping the entire format for communication with patients.

“It’s important for access to know what’s happening, because that’s where patients will bring

Hospital Payment & Information Management™ (ISSN# 1074-8334), including **DRG Coding Advisor**®, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Payment & Information Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), \$599. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Two to nine additional copies, \$359 per year; 10 to 20 additional copies, \$240 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$100 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

Editorial Questions

For questions or comments, call **Chris Delporte** at (404) 262-5545.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Melinda Young**, (youngtryon@mindspring.com).

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).

Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).

Associate Managing Editor: **Chris Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).

Production Editor: **Brent Winter**.

Copyright © 2002 by American Health Consultants®. **Hospital Payment & Information Management**™ is a trademark of American Health Consultants®. **DRG Coding Advisor**® is a registered trademark of American Health Consultants®. The trademarks **Hospital Payment & Information Management**™ and **DRG Coding Advisor**® are used herein under license. All rights reserved.



their bills," Duffy advises. "[Access managers] need to be influential and cognizant. This is a major national initiative, and a good thing for them to know in advance."

Up-and-coming job titles ambitious access managers should be aware of include vice president of revenue cycle management and director of revenue cycle management.

"That job is now paying a premium," he says. ■

NEWS BRIEFS

Number of CAH hospitals sees big jump in past year

The number of critical-access hospitals (CAHs) increased 69% in 2001, as struggling rural hospitals identify the program as a means toward financial viability.

The number of CAHs jumped by 211 in 2001 to a total of 526, according to information from the Centers for Medicare and Medicaid Services database. Another 10 hospitals had been designated CAHs by late January 2002.

Nebraska and other Great Plains states continue to lead the nation in number of facilities. Nebraska has 54, followed by Kansas (40), Iowa (32), North Dakota (24), and South Dakota (23). Iowa saw the biggest increase in the number of CAHs in 2001, adding 20. Minnesota and North Dakota each added 14. ▼

HIPAA is top concern, say hospital IT leaders

Information technology (IT) leaders at health care institutions say their top priorities for the next year are upgrading security to meet Health Insurance Portability and Accountability Act (HIPAA) requirements and building systems that promote patient safety and reduce medical errors.

EDITORIAL ADVISORY BOARD

Phoebe Bennett, RHIA
Director of Special Services
and Director of Medical
Records
Bay Area Hospital
Coos Bay, OR

James H. Braden, MBA
Vice President, EMR
Sharp Health Care
San Diego

Margaret M. Foley, MA,
RHIA
Department of Health
Information Management
Temple University
Philadelphia

Bill French, MBA, RHIA
Vice President
Payment Error
Prevention Program
MetaStar
Madison, WI

Martin J. Gaynes, Esq.
Schmeltzer, Aptaker &
Shepard
Attorneys at Law
Washington, DC

Patricia C. Goebel, MS, RHIA
Director
Clinical Information
Jennie Edmundson Hospital
Council Bluffs, IA

Darice Grzybowski, MA,
RHIA
National Manager
HIM Industry Relations
3M HIS
Salt Lake City

Lela McFerrin, RHIA
Director
Health Information
Management
Baptist Memorial Hospital
Memphis, TN

The findings are from the annual IT survey conducted by the Healthcare Information Management Systems Society (HIMSS). About 60% of the responses listed compliance with security-related provisions of HIPAA as the greatest concern, while 46% are working on error reduction and patient safety. Forty-two percent planned to upgrade inpatient clinical systems.

The survey also suggested there is sharply increased desire from last year for acquiring enterprise resource planning (ERP) systems that promote efficiency within the hospital. Fifty-eight percent of respondents identified ERP systems as important to their organization over the next couple of years, compared to 11% in 2001.

Deploying Internet technology, on the other hand, while last year's second highest IT priority, decreased eight points on this year's survey. The projected importance of Internet technology over the next two years decreased 14 points and reduced demand for Internet-based solutions. Only 38% of respondents identified web applications as important in health care in the next two years, down from 50% in 2001.

"I see a narrowing of focus in health care to initiatives related to quality and cost," reports **Charles O. Bracken**, executive vice president of Superior Consultant Company, which sponsored the survey. "Web strategies are being limited to those emphasizing practical application and positive business impact." ■