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INSIDE

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Could ISO 9000 replace JCAHO, or would hospitals benefit from both?

Opinions vary, but observers say there's overlap in systems

[Editor's note: This is the second article in a two-part series on the introduction of the ISO 9000 quality management system into the health care industry. Hospital Access Management *welcomes feedback from readers. More information on ISO 9000 is available from the American Quality Society, P.O. Box 3005, Milwaukee, WI 53201. Telephone: (800) 248-1946. World Wide Web: www.ASQ.org.]*

ISO 9000, a series of standards that has its origins in the manufacturing industry, is making inroads into health care, championed by a growing number of professionals who believe this quality management system can revolutionize the way hospitals across America are run.

But no conversation about the ISO 9000 series, created by the International Organization for Standardization in Geneva, goes on for long in health care circles without mention of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This organization, based in Oakbrook Terrace, IL, serves as the regulatory body for most U.S. hospitals, overseeing their operations through triennial surveys.

Subjects that surface for debate usually deal with the merits of one system vs. those of the other, whether ISO 9000 could or should take the place of Joint Commission accreditation, and if the two systems might complement each other.

Under the current system, hospitals that are accredited by the JCAHO are simultaneously certified for Medicare participation. Those that choose not to submit to JCAHO surveys must pass a comprehensive Medicare survey – conducted by state auditors – to keep their Medicare certification.

American Legion Hospital in Crowley, LA, was the first hospital in the country to be ISO-registered, and CEO **Leonard Spears** is a passionate ISO advocate, describing how he discovered the quality management system after his hospital "fired" the Joint Commission.

Disenchanted with the Joint Commission's preoccupation with requirements he saw as peripheral to the hospital's main mission of patient care, Spears says he likes the fact that ISO 9000 is "not industry-specific." As a

consequence, he adds, "[ISO standards] don't tell you how to run your business — they expect you to know that.

"A marked difference between [ISO and the Joint Commission] is that ISO auditors are not health care professionals," Spears points out. "They are instead quality management system auditors. They know what quality is and what a quality management system should be, and they test yours to determine whether it's functioning properly."

A fundamental quality circle

All results of ISO 9000 audits must be reviewed by hospital management, he explains. In addition, management must document any corrective action taken, and undertake preventive action where there is reason to believe it would result in better services, Spears adds.

"The results of those preventive actions themselves must be reviewed. A very fundamental quality circle is developed that is a constant requirement to have the entire hospital personnel involved. That's the biggest advantage that ISO 9000 has over Joint Commission," says Spears.

There is a basic difference in philosophy between ISO 9000 and the Joint Commission, says **Karen Brink**, a quality consultant and certified lead auditor for ISO 9000. "The ISO standard tells you the characteristics of a well-managed quality system and allows you to meet those in any way you can, in any creative manner that still meets them," adds Brink, president of Quality Paradigms Training and Consulting Inc., in Columbia, NJ.

"The Joint Commission tends to be prescriptive. You will be required to have certain positions, to do certain things. It tells a health care organization how they have to do things. ISO says this is the standard to meet and you will be held to meeting that standard," explains Brink.

Any doubts Spears had about ending his hospital's relationship with the Joint Commission were dispelled when he read a news update from the Chicago-based American Hospital Association (AHA) regarding a dispute between the two organizations. "I saw that the Joint Commission and engineers from the AHA had been discussing 15 items for a year and had agreed on a settlement of nine of those issues," Spears says. "One of those was the permissible height of a stainless steel plate on a hospital door."

Spears points out that it is his understanding that the Joint Commission made some changes to its philosophy of micromanagement. That is indeed the case, says **Maureen Carr**, associate director for the Joint Commission's department of standards.

"Beginning in about 1994 or 1995, we went from being very prescriptive and focused on departments to being focused more on the organization as a system and on the important functions within the health care system.

"We used to have standards for, say, the radiology department," adds Carr. "Now we are focused more on performance and outcomes of the entire organization."

The Joint Commission now looks in its review of hospitals at two categories: functions related to the care of the patient, and functions related to the organization itself, Carr says. Included under the patient care category are patient's rights, assessment of patients, care of patients, education of patients, and the continuum of care. Organizational functions include improving organizational performance, leadership, management of the environment of care, management of human resources, management of information, and infection control.

Despite his enthusiasm for ISO 9000, Spears says he believes there is one area in which it falls short. "The single biggest thing ISO 9000 lacks is emphasis on outcome review," he contends.

"If a patient comes in alive, we want the patient to go out alive," Spears adds. "ISO is written with the manufacturing industry in mind. If you're making widgets and one is bad, you just throw it

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out, but in health care, we want to avoid that one bad outcome. Outcome review is an area that the Joint Commission emphasizes."

Critical areas fall short

On the other hand, he says, JCAHO falls short in document control, process review, and management involvement — all areas in which ISO 9000 is particularly strong.

Those who advocate the ISO 9000 series stress its focus on ongoing, system-wide quality efforts, as opposed to the periodic panic they say is occasioned by the triennial Joint Commission surveys.

"Our head obstetrics nurse, who has been through numerous Joint Commission surveys, expressed to me that those all seemed to be processes in which we tried to put a certain face on, and then when [the surveyors] left, we were happy they'd gone," Spears says. "She said this [ISO] system made sense because it focuses on quality, and doesn't concern itself with the rights of nurses, vis-à-vis physicians, and who sits on which committee and whether they vote."

Brink notes that the ISO audits, which are done internally on a quarterly basis and by an ISO registrar once a year, "are a friendlier process, I think. They're not punitive at all. The worst thing that can happen [if a problem is found] is that you have 60 to 90 days to fix it."

Depending on the magnitude of the problem, she adds, "[the auditor] may be able to send confirmation via paperwork or may return for a re-audit, in which case you just pay for that audit day."

Carr, however, says that hospitals that gear up for the Joint Commission visit every three years and then breathe a sigh of relief when it's over are missing the point. "The idea is that the organization is continually meeting the standards," she adds.

The Joint Commission focuses more on continuous quality improvement (CQI), and has more of a customer orientation than does ISO 9000, Carr contends.

In fact, while "CQI is a philosophy, ISO is a standard that defines specific guidelines to follow in how to develop a management system," says **Bryce Carson**, vice president of quality programs with Kemper Registrar Services in Flemington, NJ. Kemper is an accredited ISO registrar that recently became part of the Bureau of Veritas Quality International (BVQI), North America, in Jamestown, NY.

"[ISO] is the launching pad to other types of management systems," he adds. "It puts the framework in place, identifies and documents the processes, and evaluates them periodically. You can't have improvement until this is done," says Carson.

Joint Commission standards "have nothing to do with CQI per se," says Carson, who also serves as standards chairman for the health care division of the American Quality Society (ASQ) in Milwaukee. "If you read the home health guidelines from the Joint Commission, they say [organizations] should devise principles which drive CQI."

Spears and others familiar with both organizations say there is common ground between the two. "If you take the Joint Commission and cause it to be a circle and do the same with ISO 9000, those circles will overlap and the area of the circles that will overlap is about two-thirds," he says. "About two-thirds of what the Joint Commission requires, ISO also requires. But not always is the work product that satisfies Joint Commission going to satisfy ISO."

There would be value in an association between ISO and the Joint Commission, suggests Brink. "They do not need to be mutually exclusive," she adds. "At Pulaski (VA) Community Hospital, they are applying both and there is a lot of overlap."

Although Carr says she does not consider ISO registration the equivalent of meeting Joint Commission standards, she concedes that hospitals

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may find it helpful in certain areas, "particularly quality control and documentation. There may be other ways it can help, too," she adds.

"Organizations that want to use ISO are free to do so. That's not contrary to anything in our standards." ■

Call center redesigns around staff flexibility

Increased staff capability, cross-training are key

A full-scale redesign of the patient access department is under way at St. Vincent Hospitals and Health Services Indianapolis, and the focus is on bringing "like" functions together, says patient intake director **John Woerly**, RRA, MSA, CHAM.

"The key is building upon those likenesses, and also building staff capability and cross-training, Woerly emphasizes. "In the past, no one was cross-trained. You were hired as a registrar and that's what you did. Now people will be working in other areas to support the needs of the department."

In the past year, he says, the patient access department has added 2.5 full-time equivalents (FTEs) for utilization review, one for secretarial duties, 5.5 for training and auditing, 15 for preregistration, three for emergency department (ED) registration, 3.5 for patient accommodations (bed control), four for core admissions, and one for systems administration.

Six FTEs have been added to the nursing staff of the hospital's call center, which is being dramatically expanded as part of the patient access redesign. He's currently responsible for about 152 FTEs overall, Woerly says, and that number will continue to increase as patient intake adds other job functions.

The new call center will be the most dramatic manifestation of the patient access redesign. After a year of planning, the project officially got under way Oct. 1, Woerly says, when he assumed management of the existing call center.

The idea, he explains, was to expand what was already a successful telephone patient referral program into a new integrated call center that will provide a more rapid response to customer inquiries. The overall mission, Woerly adds, is to enhance customer service, build customer loyalty, and increase operational efficiency.

The expanded call center, which will move into its new location in February or March, will consolidate some existing functions and add others, he notes. Services provided under the integrated call center will include:

- ambulatory scheduling;
- inpatient and outpatient observation scheduling;
- customer service, patient financial services;
- switchboard (telecommunications operators and information calls);
- nurse advice / disease management through telephone triage;
- preregistration / precertification;
- physicians' answering service;
- physician referral / CARE line;
- access to a health information library, consisting of information tapes about various diseases and injuries;
- marketing fulfillment;
- patient accommodations;
- utilization management;
- medical order processing.

The call center project, expected to cost more than $3 million and is massive in scope, with plans for 140 work stations and the integration of 30-plus computer systems, Woerly points out. The goal is that those systems — for physician referral, patient registration, and precertification, — be Windows-based, and that staff be able to maneuver among various programs on their screens as needed.

"We're to the point of selecting a final vendor partner, who will help with data integration and data design," he says. "The goal is that staff will be cross-trained, and that the automated call distribution (ACD) system will determine workload and hand out work."

The idea is that if, for instance, a large number of customer service calls — patients inquiring about their bills — come in, call center representatives who were making preregistration calls would be diverted from that task to fill the more immediate need, Woerly explains. Different representatives will have different skill sets, and the ACD system will know which calls can be handled by which employees, he adds.

Existing preregistration and precertification employees — about 25 FTEs — will be incorporated into the new call center, he says.

Because of a temporary space constraint — the space originally allocated for the call center

is now needed for a clinical department — the number of work stations will remain between 70 and 80 for about 18 months, Woerly notes. For that reason, switchboard operators, operating room (OR) schedulers, and employees handling primary care customer service calls will not be moved to the call center right away.

They will be added to the mix when the call center moves into new corporate offices within the next two years, he says.

Initially, the call center will serve three of the six hospitals that make up Central Indiana Health System, which is St. Vincent's corporate parent. As the health system expands, plans are that the center could cover seven hospitals within 18 months, and an additional five hospitals within the next 18 months, Woerly adds.

Other goals for the call center include the following:

- produce custom reports for each facility;
- maintain a minimum queue of less than 12 seconds;
- have the capability of relating customers to those in the Master Patient Index (MPI).

Perhaps the biggest obstacle to the redesign effort, Woerly says, is the politics involved in moving into a centralized mode of operation from a patient-focused care environment and institution-specific services.

"People are used to having things decentralized, and now we're going to central management," he adds. "It's difficult to roll out because it's such a change from how we've done business for the past five years. "Reaction at one of the hospitals was like, 'These are our people — you can't move this function to the corporate area.' We had to go to various meetings and get their buy-in and understanding of what we're doing."

The payoff in quality is expected to be well worth the effort, Woerly explains. "When [customers] call in to the organization, there will be consistency in how we answer, and the information we share," he says.

"There will be a database that tracks every encounter we have with the patient. For marketing purposes, we'll be able to track the first time we talk with them, and then every time they visit one of our physicians or sites or come to the hospital."

There will be a comprehensive, easily accessible record, he points out, of all the services patients receive, and of their financial history. "One of the things we've not been very good at in the past is calling a patient back to reschedule when they've missed an appointment. In the future, we'll be doing that," Woerly adds.

One concept being explored is billing advocacy. When the hospital doesn't receive a patient's payment for services provided the previous month, he says, a representative will call and say, "May we answer your concerns?" Additionally, the redesign team has looked at incorporating human resources functions, such as recruitment, into the call center, Woerly notes.

"If there are ads in the paper, there will be a specialized group [of call center representatives] that a person can call and ask about benefits and employment opportunities."

Another consideration, he adds, is to have call center representatives contact patients about annual gifts to the hospital foundation. "The concept is that any hospital business that can or should be conducted via telephone or computer could come out of this," Woerly says. ■

EMTALA clarifications help, but more are needed

Medical screening now process, not event

[Editor's note: Next month, Hospital Access Management *will examine why EMTALA enforcement remains subjective, and look at how it applies to various care settings. The EMTALA statute, regulations, and site review guidelines can be accessed on the World Wide Web: http://www.medlaw.com.]*

The long-awaited revised guidelines for enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA) have been published. They offer some help to access managers and hospitals struggling to comply with the law, but sources say more clarification is still needed.

"We have definitely taken some positive steps forward with better clarifications, but this is only the beginning," says **Charlotte Yeh**, MD, FACEP, chief of emergency medicine at New England Medical Center in Boston and a member of the Health Care Financing Administration's (HCFA) task force on EMTALA. "Not all our questions were answered, but those that were addressed are significant improvements."

Here is an overview of the significant changes

that became effective in July:

1. The medical screening exam (MSE) is a process, not an event.

This guideline clarifies the definition of an MSE, giving the example of a severe headache that could require extensive testing, including a CT scan and/or lumbar puncture. "You can substitute chest pain or abdominal pain for that," says **Larry Bedard**, MD, FACEP, director of emergency services at Doctor's Medical Center, San Pablo and Pinole (CA) campuses, and immediate past president of ACEP.

"The screening exam is not necessarily a level one or two code. It may be a comprehensive evaluation or level five code," adds Bedard.

There is clear acknowledgment that triage does not constitute an MSE, says Yeh. "The MSE is a process, not a single event, required to determine the presence or absence of an emergency medical condition," she explains. "That could be as simple as a history and physical, or as complex as multiple diagnostic procedures and ancillary services."

New definition affects pay

The new definition of an MSE is likely to affect the financial reimbursement an emergency department (ED) receives, says Yeh. "Because the definition covers such a broad range of services, it's important that any discussions with third party payers should assure payment for a full range of services, from simple to complex," she stresses. "Accepting a low-level single fee may not cover the full range of services you are required to provide under the law."

2. Prior authorization is not allowed.

This guideline clearly states that prior authorization is not permitted for an MSE and stabilizing treatment, Yeh explains. "It was not ever permissible to delay an MSE, but before it was not as clear," she says. "Now, it's explicit as opposed to implicit."

Now, if a hospital calls for prior authorization, it is violating the law, says Bedard. "Because the guidelines also clarify that triage is not the same as a MSE, you can't have a nurse do triage and then turn around and call for prior authorization," he explains.

The change is extremely important, says **Stephen Frew**, JD, a Rockford, IL-based health care attorney and consultant.

"First and foremost is the flat-out statement that there can be no prior authorization calls until there has been a complete screening and stabilizing treatment," he notes. "We often hear from managed care, 'Let's see it in writing.' Well, now it is."

Some procedures can be done outside the ED, if there is a follow-up plan of care. "There is a reference to deferring some testing for referral on an outpatient basis, but only if a patient is under a plan of care," says Frew. "Many people thought this would be an opportunity to limit the amount of care given in the ED and allow referring out. But, it is clear that HCFA will still expect a high level of stabilization and treatment before the patient leaves."

Accept referral, must treat

The guidelines also include an important caveat: the physician who accepts that referral has to follow through on it, says Frew. "In the past, these referrals have gotten made, the patient presents to a physician's office who demands money to see them, and the patient goes untreated," he notes.

HCFA will continue to cite those cases as patient dumping. "The physician who accepted the referral is obligated to do follow-up care," says Frew. "You can't refer patients out without safeguards in place to make the physician responsible."

The regulations now address the issue of when patients are considered stable for discharge.

"It's consistent with the standard of care in clinical practice that it may take time to make the diagnosis of appendicitis," says Bedard. "This reduces the jeopardy of sending these patients home. You can do that if there is reasonable follow-up, whereas before we were required to keep the patient in the ED until the diagnosis is made, sometimes hours later."

The legal definition of stabilization under EMTALA is not necessarily the same as the medical definition of stabilization, notes Yeh. "Under the legal definition, if you are going to transfer somebody, the patient is considered unstable if there is a risk of material deterioration," she says. "But typically, a physician could be taking care of a very critical patient whose vital signs are constantly in flux. Still, you clearly need to transfer the patient, because you don't have the appropriate resources at your institution."

Even if physicians do everything they can to ensure the patient gets safely from one hospital to the other, the patient is still not legally stable.

The legal definition of stabilization must be considered when transferring patients. "There is nothing that prevents you from transferring

EDs deny EMTALA risk fraud, abuse citations

Even after many hospitals are issued citations, many are still violating EMTALA, says **Stephen Frew**, JD, a Rockford, IL-based health care attorney and consultant. "There is a general sense of denial. The usual reaction is that interpretation can't be right because it doesn't make good business sense," he explains. "People don't realize that if something makes good business sense, it is probably illegal under EMTALA or Medicaid fraud and abuse."

There are still some commonly seen areas of citation, says Frew. "There are still preauthorization denials that shouldn't have ever been happening, but definitely cannot be happening now," he notes. "Also, we continue to see citations for on-call physicians refusing to come in."

Hot spot: Mental health screenings

Another hot spot is inadequate mental health screenings. "Almost every hospital I've seen in the Midwest that has been cited by HCFA has had several citations for this," says Frew. "Usually, at least one is a drug overdose or suicide gesture that was considered minor, and the patient didn't get an adequate work-up and was discharged."

Many medical staff and administrators still don't understand the obligations of EMTALA, says Bedard. "There is still a lot of confusion about how to comply," he stresses.

Some hospitals believe they are in compliance but don't understand the depth of the legislation, says Frew. "Others follow their HMO rules because they think they're supposed to and don't realize that federal law supersedes them, he reports. "So, they follow their state Medicare procedures and get nailed for a violation."

Others know the law but willfully violate it, says Frew. "For financial reasons, some administrators choose to interpret it differently, figuring they will make enough money to make that worthwhile, even if they do get cited at some point," he explains.

But that assumption is dangerous, says Frew. "An EMTALA violation has potentially devastating financial effects," he emphasizes. "To give just one example, a hospital in Arizona ended up getting suspended from Medicare from November to June, due to EMTALA and other Medicare violations. According to inside sources, it cost them over $30 million out of their cash reserves."

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an unstable patient. You just have to fulfill the appropriate transfer requirements," says Yeh. "And it's not good enough to say the benefits outweigh the risks. You have to outline the specific benefits."

3. The examining physician is the one who determines whether the patient is stable.

"They did include the word 'usually' to qualify that, but it's a definite improvement from the previous language," Bedard says. "This way, you don't run into the situation where an HMO gatekeeper says, 'From your description, I think the patient is stable, so send them home and we'll see them tomorrow." The HMO physicians do have the option of coming in and examining the patient themselves, but they cannot make that decision over the phone, he explains.

4. Peer review is recommended when medical judgment is involved.

"ACEP wanted it to be mandated that if a violation involved a question of medical judgment, HCFA had to get peer review," Bedard says. "The revised guidelines made it a recommendation but not a requirement. But it does say [that] if they do get a peer review, they should try and have someone in the same specialty — an ED physician as opposed to a cardiologist."

5. Ninety days' notice can be given for administrative violations.

Previously, any EMTALA violation called for a 23-day notice to complete a corrective plan, whether there was immediate danger to patients. "Now, there is a recognition that not every EMTALA violation mandates a 23-day termination process — that there are times when a 90-day review process is acceptable," says Yeh.

Previously, some hospitals were given 23 days' notice because they failed to send a copy of the patient's medical record, says Bedard. "If it's a matter of clinical decision making, then 23 days is appropriate, but the new guidelines allow for 90 days' notice if it's simply administrative," he says.

6. On-campus sites must have the same provider billing number as the hospital.

HCFA added language that allows hospitals to complete or conduct the MSE outside the ED only if the patient is sent to a hospital-owned facility on the hospital's physical campus and is operated under the hospital's provider number.

This is problematic, says Bedard. "Routinely we'll send patients to outpatient offices for procedures such as minor tendon repairs. It's a step backward to say you can only transfer a patient if the clinic has the same provider billing number."

Regs extended beyond intent

The new language will have unintended consequences, Bedard explains. "What this does is potentially extend EMTALA to the third of the ambulatory care centers that are owned by hospitals," he says.

"You can have a hospital-owned occupational medical center staffed by independent contractors that will now come under EMTALA. This is extending the requirements in a way that was never intended."

Hospital-owned EMS plans will find it easier to comply with EMTALA. "Previously, if ground transportation took a patient to the hospital helipad so the helicopter could bring the patient to a level one trauma center, the hospital would have been required to do a full MSE and stabilization beforehand, because they were using the hospital helipad," notes Yeh.

Under the new guidelines, EMS protocol states that patients should be transported as quickly as possible, the hospital will generally be deemed compliant, says Yeh. "They are using the helipad as a means to meet the helicopter, and the hospital is following regionally approved EMS protocols. Therefore, they are not required to do the full MSE and stabilization," she explains.

Hospitals' EMS plans need to be community-based, stresses Frew. "If you put together a community EMS plan; and patient choice is part of that plan, you might get around the necessity of signing a refusal in the field," he says."All players must be involved; not just the hospital. It must include the dispatchers, police, and fire department." ■

GUEST COLUMN

Create 'core' process to achieve seamless access

(Editor's note: This is the second of a two-part series. The first part appeared in the October issue of Hospital Access Management.)

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Achieving seamless access management will require a change in the way we do business. Last month, we looked at the human resource issues in change. This month, we will examine the process changes needed to achieve the following scenarios:

- a patient arrives on the day of surgery and goes directly to pre-op;
- a patient arrives for an unscheduled magnetic resonance imaging and proceeds directly to the procedure room;
- a patient arrives for a clinic visit and is escorted directly to a treatment room;
- a patient arrives in an emergency department and after a prompt triage and check-in is moved directly to a bed.

Achieving this level of patient service — while simultaneously assuring payment for service — is the goal of every health care provider. It's a goal that is seldom achieved. If delivering seamless access to care is a goal of health care providers, what should they do to achieve this goal?

Based on years of study and implementation, it is clear that two components are essential to creating seamless patient access:

- **A core process approach** — integrating all functions of patient access into a single "core" process that is focused on patient service and payment for services provided;
- **A process-centered performance mode**l — a comprehensive program that integrates improvements to processes, tools, organization and culture to create a high performance organization.

A single "seamless" process makes intuitive sense because this is the patient's view of access. So what is the core process of patient access and how is it created? The access core process is made up of four primary capabilities:

- reservation and scheduling;
- information management;
- securing sponsorship;
- customer service.

All of the functions necessary to facilitate patient access to care can be attributed to one of these capabilities. **(See the chart, inserted in this issue.)**

To achieve seamless patient access, the four functions must be redesigned into one overall process. The individual work steps must be re-engineered to create optimal performance of a single function and streamline interactions between functions.

The re-engineering approach should focus on the following principles:

- determining the patient's needs;
- converting from reactive to proactive environment;
- eliminating unnecessary and redundant tasks and hand-offs;
- minimizing work-in-progress (backlogs);
- establishing an environment of accountability.

Re-engineering patient access functions as one core process is critical, but will not deliver sustainable high performance results without the support of appropriate tools, the organization, and the staff culture. These key supporting capabilities are described in the process-centered performance model.

Process-centered performance model

Achieving sustainable, high-performance operations requires a comprehensive improvement approach centered on core process(es). This approach is driven by the re-engineering of processes supported by improvements in tools, organization and culture. **(See the chart, inserted in this issue.)**

The four components of the process-centered performance model are described below:

1. Process — the method by which work is completed. Re-engineering work steps, functions, and handoffs, as described above, create a proactive, accountable, patient-focused environment. The process redesign is the foundation and defines the necessary improvement to tools, organization, and culture.

2. Tools — anything used to facilitate work, including information and communication systems, processing guidelines, and resource material. Tool improvements can include simple modifications to existing information systems, major system implementations, creation of situation-based processing guidelines, and the development of on-line reference information. Tools enable core process(es) by prioritizing work, leveraging information and knowledge, and measuring performance.

3. Organization — the human capital to use the tools and execute the process. Organization improvements include new organization structures, reallocation of staff, and human resource policy changes. The structure, allocation and policies of human capital must be aligned with the core process to execute the work effectively and achieve a high level of performance.

4. Culture — the collective experiences, behaviors, expectations, and norms of the organization. Culture improvements can include reinforcement of quality expectations, incentive changes to reward important behaviors, and increased communication of organizational success.

There is no magic involved in achieving and sustaining high performance operations, and no shortcut.

Creating seamless access to care

The complexities of patient access for most health care providers require a comprehensive approach and solution. The number of care settings, the diversity of care, the unpredictability of patient volume and timing, breadth of organization coordination, and the changing requirements of payer contracts are only a few examples of the variables that must be addressed to create seamless patient access.

In addition to the complexity of the environment, there is not a single access solution that fits all health care providers. The core process approach and the process-centered performance model are the critical elements to creating a comprehensive access solution that can meet the requirements of a specific health care provider.

Creating seamless access to care can take multiple years and is difficult to achieve. However, the benefits of operational effectiveness, financial performance improvement, and strategic differentiation are enormous.

Besides being the right thing to do for patients, seamless access to care is a critical capability for

success in an industry increasingly driven by expanding customer choice, pressures to reduce costs, changing payment requirements, soaring service expectations and aggressive competition for market share. Managing the human side of change can make the process less painful, produce fewer unintended consequences, and ensure the change is a lasting transformation.

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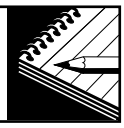
GUEST COLUMN



Wearing another hat may not be a bad idea

By **Jack Duffy**, FHFMA
Director of Patient Financial Services
ScrippsHealth, San Diego

Many providers do not consider the access manager a key component of managing risk. I would like to make a case, however, for upgrading the skills and awareness of every access manager to perform this function.

First, the traditional risk model calls for the physician to be the principal control point for patient care. This model has served us for all of the modern health care era. Times have changed, however, and traditional models are breaking down. At one time, the role of insurance companies was to collect premiums and pay claims. They existed completely outside of the care model.

With the invention of managed care, the traditional model began to crumble. First, managed care organizations (MCOs) began to employ physicians in a variety of roles. The roles of physicians now include those of "gatekeepers," medical managers, staff models, and others. This aligned the financial success of the physician with that of the insurance product. As the staff model moved to other structures, physicians assumed more complex roles than the care of individual patients.

Through the mechanism of prepayment, the physician became responsible for "global" budgets. As a result, physicians could literally run out of money and end up "upside down." Into this changing environment now comes the "hospital partner."

Many hospitals have moved ever closer to their related physician groups by using a variety of mechanisms. These include self-owned MCOs, owned and sponsored medical service organizations, and other forms of practice management.

In recent years, contracts with MCOs have included global risk contracts where the physician and hospital share the majority of the premium payment in exchange for providing virtually all of the care.

In these new roles, the decisions related to access to care become an ever-increasing concern. Will the traditional separation of insurance and care providers withstand the scrutiny of the legal community?

There is a strong possibility that the traditional legal protections associated with the sale of insurance will erode. At that time, hospitals — by virtue of their physician relationship — may be held responsible for adverse outcomes associated with the denial and delay of care. The access manager in the future may have to be aware of how medical decisions were made.

Access managers also will need to be aware of a patient's status, and know the answers to the following questions:

What are the patient's appeal rights?

Where is the patient in the appeal process?

This information will feed into a decision process that either allows care to continue or refers the patient back into the community. These point-of-service calls may have a significant influence on future claims and insurance premiums.

I recommend that access managers continue to focus education and research on these areas. Professional organizations should support forums and discussion to keep information flowing to access managers across the country.

(*Jack Duffy also serves as consulting editor for* Hospital Access Management.*)* ■

ACCESS FEEDBACK

Is there a better way to comply with Medicare's medical necessity rules?

"How are other hospitals complying with the Medicare medical necessity guidelines?" asks **Tammy Cieplowsk**i, director of admitting at Beaufort (SC) Memorial Hospital. "Right now at our hospital, admitting is screening for medical necessity prior to the patient having the service; but I want to know if we're doing it the best way. Has somebody found a better way?"

Beaufort Memorial went live in April with Boston-based Iatric Systems' medical necessity screening software, Cieplowski says, but there are still problems with the process.

"For example, if the patient is having a CAT scan, which can be 'with contrast' or 'without contrast;' admitters can't order the test, so the radiology technicians order it — they know the level of the test," she explains.

If the test fails medical necessity, the technician prints a hospital issue notice of non-payment (HINN) for the admitting department, and the admitter retrieves it and walks over to the radiology department to have the patient sign it, Cieplowski adds.

Logistically, this chain of events is less than desirable, she says, but the alternative would be to have the technicians get the HINN signed, something Cieplowski is reluctant to do. "I'm concerned about having a tech perform a financial function," she notes. "Do you want a caregiver giving financial data to a patient?"

Cieplowski also wants to know how her colleagues are dealing with "canceled preops" — cases whereby a patient comes in for a preoperative study (chest X-ray, complete blood count (CBC) and EKG), and then the scheduled surgery is canceled, perhaps because of an abnormality on the EKG. Procedures that had been preoperative tests not subject to screening for medical necessity revert to outpatient procedures that have to be screened. "How are others handling this?" she asks.

'Where do you draw the line?'

And what about emergency department (ED) scenarios? "You're registering the patient, and the doctor wants a CT for headaches. The patient may be critical. Where do you draw the line with severity of illness?" she asks. "Do you tell [a critically ill patient] they may be responsible for $600 to $700 worth of tests?"

[Editor's note: If you have a solution to Cieplowski's problem, please call Hospital Access Management *Editor Lila Moore at (404) 636-9264 or send e-mail responses to lilamoore@mindspring.com. Cieplowski can be reached at Beaufort Memorial Hospital, P.O. Box 1068, Beaufort, SC 29901. Telephone: (843) 522-5110.]* ■

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