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Hospital streamlines ED patient flow with commitment, creative thinking

Wait time down, collections up; Program WOWs hospital ED

A dramatic overhaul of the emergency department (ED) process at Paradise Valley Hospital in National City, CA, began with a single question from the director of emergency medicine.

In the midst of an animated discussion of the myriad problems in the facility's ED — where registrars behind thick glass partitions faced noisy, contentious patients on one side and nurses complaining about tardy face sheets on the other — he asked, "What if we just shut the windows?"

It's indicative of the outside-the-box thinking of the team that was brainstorming solutions, say **Melanie Betancourt,** FHFMA, director of patient financial services, and **Stephanie Baker**, RN, CEN, MBA, director of emergency services, that the answer was not, "We can't do that."

Instead, Baker adds, the response was another question, "How would we work the process of getting patients triaged and out of the department?"

With that question, she says, the idea of bedside registration was born, along with a project name — Wipe Out Waiting, or WOW.

This six-person core group, which also included the ED admitting supervisor, the admitting manager, and the nursing manager, identified in April 2002 the concepts it would work toward, Betancourt notes. The team later expanded as needed to include a secretary, nurse educators, registration line staff, and information systems and security personnel, among others.

The representation of security personnel was key, Baker points out, because with no glass to protect registrars, security would have to be enhanced. "Our hospital is in a low socioeconomic area, and the waiting room tended to be wild with people complaining, wanting to get back [to the treatment area] to see family members, and homeless people coming in just to get shelter."

Other concerns, she adds, included the constant interruption of registration staff, not only by patients' friends and family, but also by people

asking directions to other areas of the hospital, and the need for patient confidentiality, underscored by the Health Insurance Portability and Accountability Act's privacy standard, which became effective in April 2003.

A crucial issue was the need to accommodate the 5%-8% increase in patient volume the ED had been experiencing for each of the previous three years, but without adding space, which is limited, Baker says.

The project's underlying concept, she explains, was to eliminate the typical ED experience of sequential processes interspersed by wait times — the patient signs in, is seen by a triage nurse, goes to the lobby to wait for his or her name to be called to give basic registration information, then sits down and waits to be summoned by a nurse, and so on.

At the outset, Baker continues, the team looked at every segment of time in the ED process, something the hospital already tracked. The segments are as follows:

- triage to bed;
- bed to interaction with physician;
- physician interaction to disposition (a decision on what to do with the patient);
- disposition to discharge (how long it takes to either admit the patient or send the patient home, for example).

"The cycle time from when patients got to the room to when they got out wasn't bad," Baker says, "but the waiting room was where we were losing a lot of time, so reducing triage-to-bed time became our goal. That's where we decided we could get the biggest bang for the buck."

The WOW project team met weekly, setting short- and long-term goals, and by August 2002, was ready to do a two-week test to see if the concept would work, she notes. The team presented its plan to the hospital's senior leadership team, which approved the purchase of three laptops and other equipment, as well as the temporary hiring of additional registrars and security personnel, Baker adds.

"We knew if we were moving to bedside registration, we would have to have laptops and, in a perfect world, would want to have 24-hour security."

Approval came with the condition that the improvements ultimately must be budget-neutral, she says. "We would have to make up the salaries by improving registration, collecting copays, getting good financial data, and employing a cash-pay program — but first we had to find out if [the new process] would work."

It was evident right away that the new process was a success, Betancourt says, with triage-to-bed time shortened dramatically. What also was clear when the trial period was over, she notes, was that it would be a mistake to stop the momentum that had been created.

"The core group came back together and said, 'We have to keep going. If we stop and then try to start again, we'll have an all-out war on our hands,'" she adds. "We had no idea how painful [the transition] would be. To go through that and then go back to the way it was before wasn't going to work."

Since the WOW process was implemented, the

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WOW's success comes from a number of factors

Hours spent 'going through the flow'

Several key innovations contributed to the success of the Wipe Out Waiting (WOW) initiative in the emergency department (ED) of Paradise Valley Hospital in National City, CA, part of the Adventist Health System.

In addition to slashing patient wait times, the WOW program led to dramatic increases in point-of-service collection and coverage for unfunded patients and a calmer, more orderly waiting experience, among other improvements, according to patient financial services director **Melanie Betancourt**, FHFMA, and emergency services director **Stephanie Baker**, RN, CEN, MBA. Here are some of the contributors to the program's success:

• A new on-line financial screening process

Within the hospital's existing Siemens MedSeries4 patient accounting software, explains Betancourt, is a functionality called USP (universal secondary payer) that typically is used in asking patients the questions needed to determine if Medicare should be the secondary payer on an account.

Even the Malvern, PA-based vendor points to the functionality's use for that purpose alone, she says.

Betancourt points out, however, that she has made use of the USP to create a decision tree for on-line financial screening. "[Registrars] ask a series of questions and based on the answers, get direction on how to approach getting that person funded."

She suggests that users of the software take a look at other possible uses for the functionality, noting that it has greatly improved the hospital's financial screening procedure.

• Hours spent "going through the flow"

"Making certain we had accounted for all the various things that could happen — the different points of entry, the different conditions, how the security component would fit in" when the hospital closed the ED registration windows and went to a bedside registration system was crucial, Betancourt stresses. "We spent many hours going through the flow."

Part of that preparation involved the enhancement of the master board used to track patients' progress through the system, she says. With the use of initials — not full patient names — to protect privacy, progress is indicated by movement across the board as various steps are completed, explains Betancourt.

Although the master board was not new, adds Baker, "we made it more specific to follow the WOW process, and added financial screening."

• Room-specific registrars

As part of the WOW program, registrars are assigned to work with the same bank of rooms and the same nurse throughout a shift, Baker notes. In addition, a registrar follows an account from start to finish, rather than handing off responsibility at various stages of the process, she says.

As a result, Baker adds, the quality of information has improved, and the amount of errors has been reduced. Contributing to those results is the ongoing "monitoring, reviewing, and tweaking" that take place, Betancourt says. "We have full-on quality control, with 100% of accounts validated to make sure before the bill is dropped that certain data elements are accurate."

• A three-bed overflow unit

Part of a "step-down" unit the hospital was having trouble staffing was called into service to help expedite ED patient flow, Baker says. "If necessary, we can put one nurse there and use it as an overflow area for three stable patients who have already been admitted and are waiting to go upstairs. That opens up three beds in the ED." ■

Paradise Valley ED has shown a 27% reduction in triage-to-bed time, from 45 minutes to 32 minutes, Betancourt says, while point-of-service collections have increased from about $160 per day to about $300 per day.

To put the collection increase in perspective, she says, it's important to note that that National City has one of the lowest per capita incomes of any city in California. "In the past, days would go by and not a single copay would be collected."

With the same number of beds, Baker says, the EDs average daily census has increased about 20%, from 84 patients a day in 2001 before WOW was implemented, to 104 at present.

And despite the census increase, Betancourt points out, there has been little or no increase in the number of unfunded accounts. "That tells me we are doing a better job of verification and getting information into the system."

The implementation throughout the Adventist Health System, of which Paradise Valley is a part, of the HDX interactive process for eligibility checking has been "very beneficial," she notes, because of the hospital's high number of Medicare and Medi-Cal (the state's version of Medicaid) accounts.

When time came to start the new process, Baker says, "we shut the registration windows in

the lobby and pushed couches against them," and security guards began 24-hour staffing of a podium in front of the triage booth.

What happens now is that the security guard greets people who approach the area, she explains, and asks if they're there to be seen in the ED or responds to requests for directions — relieving registrars and the triage nurse of those time-consuming tasks.

If the person is an ED patient, he or she fills out a short form that asks for name, date of birth, chief complaint, and time, Baker adds.

The triage nurse, who is in a room with a window that protrudes into the waiting area, speaks to the patient, asking what he or she is there for and, if busy with another person, does an "across-room assessment," she says. The nurse then brings the patient in for a "quick triage," lasting no more than two minutes, in which she asks about medications, allergies, and gets vital signs.

In the meantime, Baker continues, the nurse takes the form the patient has filled out, verifies that information, and passes it through an opening into the registration area, where the registrar starts a miniregistration on the patient.

If the patient has been to the hospital before, the account immediately comes up on the computer screen, she adds. If not, a medical record number is assigned.

The patient then moves from triage into the registration area, where the registrar verifies the demographic information and asks the patient to sign the conditions for treatment form. An identifying wristband also is put on the patient at this time, Baker points out, so that, if there is a wait, the nurse can begin any standard procedures she deems necessary, such as a basic lab test.

"It is also a 'psychological capture' of the patient," she notes. "If patients are banded early, they are less likely to leave before treatment." And if the patient does leave before treatment, Baker adds, "we could still make a chart, because we have the basic demographics and could call and see how they are."

If a bed is open in the treatment area, the patient goes directly to a room, not back to the lobby, Baker says. "The triage nurse works closely with the charge nurse, using a portable in-house phone, to see which beds are open. The chart follows the patient to the treatment room, where the nurse assigned to that room takes over care.

"This gets the patient to the room quicker and gives the physician the opportunity to get in faster," she adds. "Typically, the physician writes the orders, the nurse initiates the orders, and while waiting for labs or X-rays, the registrar goes in and gets further information from the patient."

While waiting, Baker says, the registrar is verifying insurance and, in the case of unfunded patients, may give the person the appropriate paperwork to apply for Medi-Cal. For unfunded patients that don't qualify, the hospital has a discount program in place.

Because the ED area is completely locked down, there is not a problem with patients leaving after treatment but before discharge, she points out. "We have them all leave through the main entrance, which is where the main registration and triage happens, so there is one more chance for a registrar to talk to the patient if needed."

The only difference in the process in the event of a full house is that the next two patients to receive treatment are put on a couch that is just outside the registration area, Baker explains. "This reminds the staff that there are always people waiting."

If there are more than two people waiting, they do have to go back to the lobby, she says. "We try to give them an estimate [of how long the wait will be], and the triage nurse makes rounds every 15-30 minutes to see if they're OK. If the patient's condition changes, they can upgrade as needed."

Calm and control

One of the most striking things about the WOW process, Baker continues, is that it completely changed the dynamic of the ED waiting area. "It's now calm, well controlled, and security has taken over the visitor-pass area. [The security guard] has a portable phone to check with the [treatment area], and assigns yellow badges to those who are allowed to go back."

In the past, she notes, a nurse or registrar might open the door for one person, and several more would slip by.

"We also have a better idea at night of who is coming in and out of the facility — we call them visitors, vendors, and violators — and if anyone looks shady, security has time to interact with them," Baker says. "We get very specific notes from patients, saying they appreciate the changes."

Because of the more controlled setting, she adds, "the triage nurse is much quicker and more focused because she is not being interrupted 50

times. She can keep a close eye on the lobby because she is not managing as many people. Most are going [directly] back to a room."

Baker and Betancourt emphasize that the project's success would not have been possible without a cooperative multidisciplinary team.

"Admitting can't do it alone," Betancourt stresses. "When we do a presentation for our sister hospitals or other local facilities, we always emphasize that having the integrated team working together is really important."

"We were certainly dependent on the inpatient side," Baker says, noting that the success of the ED operation is tied directly to its ability to get patients admitted in an efficient manner.

Although a bed manager had been hired before the WOW program began, she adds, her role was redefined as a result of the ED initiative. "We did a big push of what it meant and why we were trying to get patients out of the ED so quickly."

"As a team, we were very fortunate," Betancourt says. "There were no ego problems, no one saying, 'The physicians don't want to do it this way.' Everybody was bringing ideas forth to make sure we were compliant in all areas — particularly with EMTALA (Emergency Medical Treatment and Labor Act) — and that we would treat patients with respect and protect the hospital."

(Editor's note: Melanie Betancourt can be reached at betancma@pvh.ah.org. Stephanie Baker can be reached at bakersj@ah.org.) ■

Going from good to great is Studer program's goal

'It's all about service excellence'

Aligning with the health care customer service model of the Studer Group — whose Road Map to Excellence is guided by five pillars: service, quality, people, finance, and growth — was a natural fit for Providence Health System, says **Patricia Weygandt**, manager of access services at Providence Milwaukie (OR), one of three system hospitals in the Portland area.

"It's all about service excellence," she adds. "The pillars of the [Gulf Breeze, FL-based] Studer Group come very close to our strategic priorities."

What's striking about the Studer program, and gives it more substance than the average customer service initiative, Weygandt contends, can be summed up in one word: accountability.

"It's a change in culture, and it requires buy-in from everybody within the health system," she says. "It's not just, 'This is a good idea,' and maybe you do it and maybe you don't. It requires the complete support of all levels of leaders."

Information on the company's web site, www.studergroup.com, describes how it has applied to health care the concepts in the book, *Good to Great,* by Jim Collins, which is about the momentum created by the power of continued improvement and the delivery of results.

Under the Studer plan, Weygandt says, every member of the organization is asked to sign a service commitment and receives a star pin to wear as evidence of that commitment. Providence Hood River — also located in Oregon — was the first system hospital to adopt the program, with some modifications, she notes, and the three Portland-area facilities began implementation in late November and early December 2003.

A three-tiered rollout of the program started with manager education, and was continuing this year with an employee forum, or seminar, on service excellence, Weygandt continues. "It will take from a year to two years to get it fully implemented."

Highlights of the program, she says, include the following initiatives:

- **Leader rounding**

Using a "rounding log," managers go to employees and ask a series of questions, Weygandt explains. "We ask if there are any coworkers they would like to recognize, and why, and then if there are any physicians they'd like to recognize, and why. Then we ask, 'Is there anything I can do that will help you with your job?'"

The form on which these responses are recorded **(see illustration, p. 30)** also has a place to indicate action taken by the manager, she says. "Every manager is expected to do one rounding a week, and then the logs are sent to administrators, who keep a record."

Weygandt said, for example, that she rounded on one of the emergency department registrars, asking the employee, "What's going well down here. Is there anyone I can recognize?"

The registrar immediately gave the name of a nurse, citing her compassionate attitude, and then listed four physicians who are always supportive of admitting staff, as well as a co-worker and another nurse.

Asked if there was anything that could be done

(Continued on page 31)

Leadership "Service Excellence" Rounding Log

Interviewer:	Interviewee:	Date:	Location:
"What's Going Well?"			

SERVICE OPPORTUNITY		ACTION TAKEN
Employees to Recognize: Employee	Reason	Thank You(s) ☐ Home ☐ Office/Dept ☐ Email
Physicians to Recognize: Physician	Reason	Thank You(s) ☐ Home ☐ Office/Dept ☐ Email

Ideas for Improvement:	Follow-Up Required:
Other:	

Source: Patricia Weygandt, Providence Milwaukie (OR), Providence Health System.

to make her job easier, the registrar mentioned that the department's insurance eligibility software was not working properly. Weygandt wrote personal notes to those mentioned, citing the specific reason for the thank-you, and followed up on the software service request.

• **The five-10 rule**

Within five feet, employees are expected to make eye contact with and greet whomever they meet, be it a co-worker, physician, or patient. Within 10 feet, they are expected to make eye contact and smile. Those who've made this commitment are given a "smile" button to wear.

At Providence Milwaukie, Weygandt says, "we have all noticed a real difference in the hallways and throughout the hospital as people have acknowledged patients and co-workers. People who before would put their head down and look away are now saying, 'Hello' or 'Good morning,'" she adds. "Those who are a little reticent can't help but respond."

Asked if a required greeting might seem artificial to some, Weygandt notes, "If it is artificial, then people need to examine their attitudes and why they're here. That's how culture change happens. It's amazing how contagious it is. You see a light in patients' and families' faces when they are recognized and acknowledged."

• **Managing up**

"This means positioning someone or something in a positive light," Weygandt explains. "An example would be to say to a patient, 'Dr. Smith is your physician. He's a very good surgeon. You're in great hands."

"You can almost always think of something positive, even if it's about equipment," she adds. "You can say, 'We've just installed an MRI [magnetic resonance imaging machine] that is the best in the field."

To contrast, she notes, "managing down" would be to tell employees something like, "Management won't get us the equipment we need," or "I called the doctor three times about your pain, but he won't call back."

Because it's such an ingrained habit to consciously or unconsciously pass the buck to avoid being blamed, Weygandt points out, managing up is the most difficult practice for staff to implement consistently.

Follow-up — as in the seven thank-you notes generated by one employee — is imperative to the program's success, she emphasizes. "If you don't follow up, it's just so much lip service. If it doesn't translate into action, it's just one more program that will fall by the wayside."

Although the follow-up described above was more extensive than the norm, Weygandt notes, there is no question the Studer program represents a major time commitment. "It's worth it," she says. "It's part of what we need to do to turn us from a good hospital to an excellent hospital. Many times people are happy with good, but we're not."

Program practices yet to be rolled out, she says, include identifying the level of each employee's performance as either a 5 (highest), 4, or 3, with appropriate feedback given, and instituting telephone calls by nurses to all patients following discharge.

The idea behind implementing the program in phases, Weygandt explains, is to "hardwire the behavior change for at least three months and then move on to the next step." That way, she adds, "it becomes part of the everyday routine."

(Editor's note: Patricia Weygandt can be reached at patricia.weygandt@providence.org.) ■

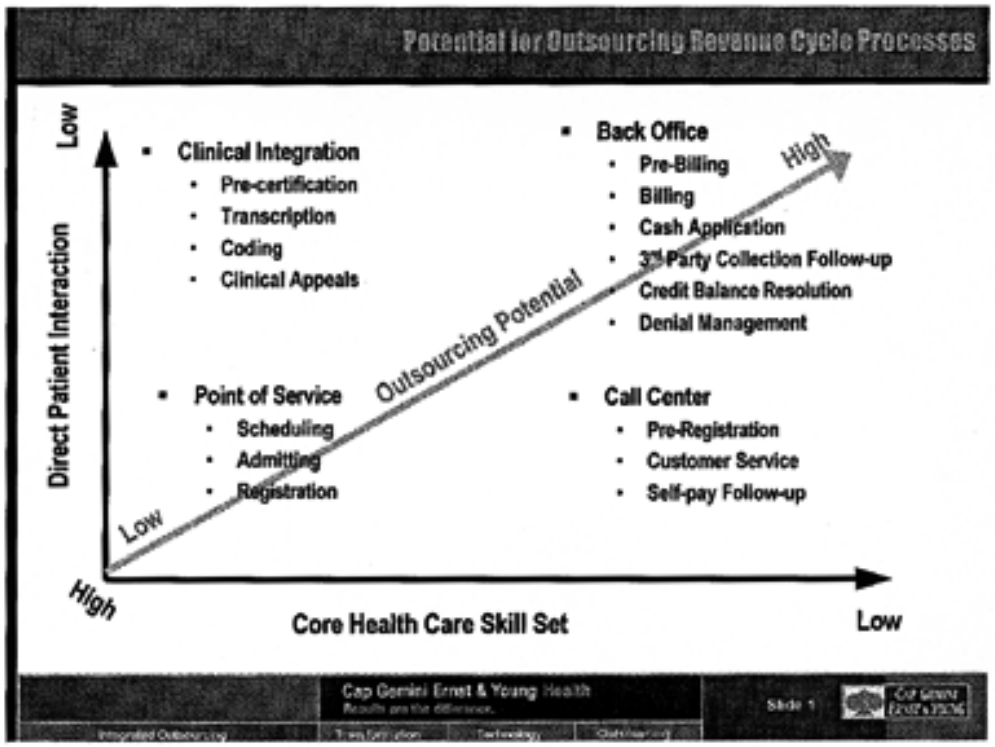
A stepwise approach to outsourcing revenue cycle

By **Elizabeth Guyton**
Cap Gemini Ernst & Young
Atlanta

Health care organizations are discovering, as many industries have already learned, that thriving — even surviving — in a competitive marketplace means concentrating their talent and experience on what they do best, and offloading noncore services and administrative functions to vendors who can do them better, faster, and cheaper.

In principle, business process outsourcing is little different from sending out the hospital laundry. The difference is that outsourcing revenue-generating, mission-critical processes requires a much higher skill level, and a high level of collaboration and trust between customer and vendor. Such a partnership entails some risk and requires careful vendor selection.

Outsourcing revenue cycle processes is intended to improve cash flow and process effectiveness by introducing leading practices and eliminating activities that don't add value. In processing accounts receivable, outsourcing can help to collect receivables sooner and reduce write-offs of bad debt.



Source: Elizabeth Guyton, Cap Gemini Ernst & Young, Atlanta.

By standardizing workflow and data collection, a knowledgeable vendor can help reduce errors in claims processing and improve efficiencies throughout the revenue cycle. Improving the timeliness and accuracy of initial claims, and shortening the turnaround time of any denials that still occur can further enhance cash flow.

Clinical integration processes can be improved, too. Knowledgeable personnel using state-of-the-art methodologies can improve the specificity, completeness, and consistency of all clinical documentation, including bills and insurance claims.

Outsourcers can consolidate the business office and support functions of multiple hospitals, departments, or acquired physician practices into a shared services model that provides more effective services at lower cost.

Outsourcing point-of-service functions can reduce the time patients spend in admitting and registration, and provide self-service capabilities, both of which dramatically improve patient satisfaction. Best of all, outsourcing the revenue cycle can accomplish all these benefits for substantially less money than health organizations spend today for support services that don't perform as well.

An outsourcing vendor should be prepared to transform business processes as it takes on each new responsibility, and not merely take over existing processes and accomplish them with existing methods. For better results, an outsourcing vendor must possess the talent, expertise, comprehensive methodologies, and technological support to transform processes across the entire revenue cycle into leading practices.

This transformative approach is key to sustainable, high-value improvements in financial performance. Process transformation makes the difference between saving money through outsourcing and achieving market dominance through financial leadership.

Selecting an outsourcing vendor who can deliver maximum benefit to a health care organization's bottom line must be a top priority. In general, the vendor of choice should have excellent references and extensive experience in both financial services and health care management. An outsourcing vendor should be able to show a long and consistent track record of helping health care clients improve their revenue cycle performance.

Cost should be considered, but the prospective customer should beware of companies trying to buy themselves into the growing and lucrative health care market. These companies, some with financial expertise in other industries, are willing to offer low prices for the privilege of gaining health care experience — usually at the provider's expense. Here are some other criteria that should be considered:

- **Focus on customer service**

Outsourcing vendors who place emphasis on training and retaining a highly skilled staff make excellent business partners. These companies realize that satisfied, well-treated employees are likely to provide good customer service. Training costs can be applied to improving the knowledge and skill levels of employees who aren't taking their expertise to better opportunities.

This customer-centered attitude reflects well

on the health care provider. Patients appreciate helpful, competent assistance from a provider's business office. Cumbersome admitting procedures, clerical errors, and unsatisfying interactions with "customer service" personnel are a prime cause of customer defections.

• **Deep revenue cycle knowledge**

It is vital for an outsourcing vendor to understand the processes and issues involved in fulfilling revenue cycle functions for health care providers, who operate from a much different business model from other enterprises. In addition to expertise in general accounts receivable management, a vendor must have deep knowledge of Medicare billing requirements, Blue Cross issues, local medical regulations, and regional billing methods. The vendor must be able to handle transactions with the local managed care payer and the federal government, with expertise in processing complex, detail-oriented forms, such as the UB 92.

• **Resource availability**

An outsourcing vendor should have sufficient and knowledgeable staff to handle its responsibilities effectively. Special skills that should be available include expertise in billing, collection and follow-up, accounts receivable analysis, and IT support.

• **Appropriate management and client service infrastructure**

Effective project management improves the collaboration between vendor and client. Having the right personnel and technologies dedicated to supporting each engagement facilitates greater improvement in financial performance.

• **IT competence**

Many health care organizations seek an outsourcing vendor to provide the IT expertise and state-of-the-art technologies they lack. For its part, the vendor must be familiar with the core business applications used by health care clients, notably ADT (admitting, discharge, and transfer) and PFS (patient financial services) systems. The vendor should have the capability to quickly and flexibly generate a wide variety of reports from its core information systems.

These reports are important tools for decision support. The vendor must also have experience with automated billing systems, and competency in workflow management and interface development.

• **Overall understanding of provider issues**

Expertise in revenue-cycle processes is not enough for an effective outsourcing relationship. Vendors should understand more general health care challenges, such as patient relations issues that can contribute to patient satisfaction and loyalty. Business office personnel also should understand how the integration of detailed, correctly coded clinical records benefits the patient at every point of contact.

Outsourcing is not an all-or-nothing proposition. Although the eventual goal may be to outsource the revenue cycle end-to-end, giving up control of revenue-generating processes has risks. To manage risk, many health care organizations first offload back-office functions such as billing, collection, denial management, and clinical documentation and coding, which require little or no patient interaction. **(See figure, p. 32.)**

Many organizations achieve dramatic financial improvements at this limited stage of outsourcing. They find that the outsourcing vendor's methods and personnel deliver significant improvements in cash flow, accounts receivable, and other financial metrics at lower cost.

Next, the provider may contract with the outsourcing vendor to establish a call center to handle direct patient interactions such as pre-registration, self-pay follow-up, and customer service requests. As the relationship matures and better processing methods become available, outsourcing has the potential to encompass the entire revenue cycle and all points of patient service.

An outsourcing vendor that can combine business process expertise with thorough knowledge of health care issues is a provider's best guide to transforming the revenue cycle from a support service to a competitive advantage.

(Editor's note: Elizabeth Guyton is a vice president in the health consulting practice of Cap Gemini Ernst & Young and leads the national revenue transformation service line. She has more than 20 years of health care management experience concentrating in the areas of accounts receivable and financial management.) ■

Boost reimbursement with reorganization, teamwork

'Build, maintain relationships'

Creating the most efficient staffing arrangement possible — along with fostering effective working relationships with those outside the access department — was integral to the development of a financially successful patient access department,

says **Patti Daniel**, MS, CCM, LPC, LMSW/AP.

Daniel, who recently ended a stint as director of admissions and registration at a large publicly funded Texas hospital, helped the organization obtain millions of dollars in reimbursement for services that otherwise would not have been covered. **(For more information on Daniel's initiatives, see the February 2004 issue of *Hospital Access Management.)***

The reimbursement initiative

When she became director five years ago, explains Daniel, who spent a total of 19 years with the organization, there were financial counselors doing registration and registrars doing registration "and they all reported to different managers."

Daniel divided the 300-person department into registrars and financial counselors to allow each group to focus more on doing that job well, she says, and also created a second associate director position, so that there was an associate director to manage each group.

As a direct result, she notes, there was a large increase in the conversion of previously unfunded patients to Medicaid and other programs during her five-year tenure, along with revenue increases amounting to more than $100 million above budget.

Another key to the success of her reimbursement initiative, Daniel says, was the fostering of relationships with clinical staff, the hospital's third-party eligibility vendors, and the state Medicaid eligibility staff. "If you don't build and maintain those relationships," she adds, "you lose a lot of money."

Although the attitude of many hospitals — toward both Medicaid workers and third-party eligibility vendors — is, "We're paying you to do a job, just go do it," Daniel says, she has a different philosophy."

"I've always considered it a win-win situation to make sure the third-party vendors had everything they needed to be successful," she notes. "I did everything I could to make them profitable, because every time they got somebody certified, we got paid."

She met with the contracted vendors each month, Daniel says, and reviewed their productivity. There was an advantage to having the accounts divided among more than one company, not only because of the large volume of business the hospital generated, but because it encouraged competition, she adds.

"Another thing I did was to allow [the third-party vendors] to have interview slots with [the on-site] Medicaid staff," Daniel says. "Some hospitals require that third-party eligibility companies get patients certified, but don't allow them to use [hospital-based] Medicaid workers."

Her thinking, she explains, was that it was the hospital's patients that were being taken care of, so why not make it a smoother process for them. "It not only increased the number of people we got on Medicaid, but it made it easier for the patients because they knew where to go. Some undocumented patients won't follow through in a Medicaid field office, but felt comfortable going to the [state] Medicaid workers in our hospital."

Additionally, Daniel was proactive in obtaining new third-party contracts, putting out new requests for proposals since the two companies that had been in place had dwindled to one, which had trouble handling the workload, by the time she became director.

"Once two new companies were chosen, we needed them to ramp up pretty quickly so we would not lose money," she notes. "I set some aggressive goals for the companies, providing them quick access to inpatients and monitoring their performance."

As a result, Daniel adds, the productivity of the companies contracted to do the eligibility work is 300% greater than it was five years ago.

Daniel's close working relationship with the Medicaid staff also contributed to the access department's financial successes, she notes. "When I started working with the patient access department, there were only two of the contracted 30 Medicaid workers on board, and no one was even talking to them, much less making referrals to them."

Her efforts to repair the rift, Daniel points out, included staying in regular communication with the Medicaid workers, renovating their office, and holding appreciation receptions in their honor.

"They now love working there and know how much the hospital appreciates them," she adds. "It was all about building and maintaining the right relationships."

A move that benefited both the Medicaid staff and the hospital, she adds, was the offer to provide a Medicaid training site on campus. "This was a way to build our own work force and to ensure we had the Medicaid graduates to keep a full complement of staff."

Also, Daniel says, the state Medicaid office gave approval to pay overtime to the workers, which enabled the office to extend its hours. "This allowed patients who could not make appointments during

regular business hours to apply up until 8 at night and on weekends. Thousands of additional patients were certified as a result."

To further enhance the financial viability of the system for which Daniel worked, the consulting firm Cap Gemini Ernst & Young (CGEY) was brought to the table to assist in an initiative called "Transforming Care."

"The health care system was very progressive in trying to find alternative funding for its patients," notes **John Woerly**, MSA, RHIA, CHAM, Indianapolis-based senior manager with CGEY. But in a period of decreasing funding from governmental and other public bodies, he points out, the question becomes, "How can an institution go further to enhance financial viability?"

Teams were deployed in all areas of the organization to analyze current processes and propose future processes that would improve both clinical delivery and financial stability, Woerly adds. The revenue cycle team, he notes, focused on improvements in patient access, health information management, and patient financial services. These ranged from reduction in discharge-not-final-billed activities due to charts awaiting medical record coding, to cash acceleration, which focused on getting old bills paid.

Patient access, he says, focused on three initiatives, which he lists and describes as follows:

1. Getting scheduling information in a timely manner, with attention to key data elements needed for clinical and financial clearance, such as diagnosis, procedure, ICD-9/CPT codes, precertification/authorization numbers and primary care provider referrals.

2. Performing clinical and financial clearance, including LMRP (local medical review policy) review of outpatients and IS/SI review of inpatient admissions/outpatient observation cases.

Emphasis in the past, Woerly notes, was on performing pre-registration only on funded patients, which in this case were a very small percentage. The newly designed focus, which called for the creation of a call center environment, combined care management (utilization review) and pre-registration/verification/authorization functions.

The emphasis, he adds, would be to ensure clinical and financial clearance of all patients, and to "thrust this function out to the community." In the past, most of the intake process was unplanned, resulting in large numbers of patients literally waiting all day for services.

This was not only a customer satisfaction issue, but a capacity management issue, Woerly explains. "The future state plan calls for scheduling financial counseling appointments for unfunded patients, as well as deploying a deny/delay policy for non-emergent, elective cases."

3. Enhancing time of service collections through the education and communication of patient liabilities (copayments, deductibles, co-insurances, deposits and outstanding balances) at every point of contact — scheduling, financial clearance, registration, financial counseling and at the point of service.

An analysis was conducted to establish goals, reports were designed to provide feedback, and training was conducted for more than 650 people.

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CMS makes change to critical access rule

Two new policies that will increase reimbursement to critical access hospitals for Medicare beneficiaries — and allow those hospitals to use up to 25 beds for acute care services — have been implemented by the Centers for Medicare & Medicaid Services (CMS).

The policies implement provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which is intended to bolster health care services in rural areas, according to a recent announcement by CMS.

As a result of those changes, payments to the 863 critical access hospitals are expected to increase by

$900 million over the next 10 years. In addition to increasing the permissible number of beds, the new policies put into effect a provision of Medicare law that increases the payment for both inpatient and outpatient services rendered by critical access hospitals from 100% to 101% of reasonable costs. More information is available at www.cms. gov. ▼

NPI final rule released by CMS

A final rule establishing the National Provider Identifier (NPI) as the standard unique identifier for health care providers filing and processing health care claims and other transaction standards called for under the Health Insurance Portability and Accountability Act (HIPAA) has been released by the Centers for Medicare & Medicaid (CMS).

The NPI is expected to improve efficiency and reduce costs by eliminating the need for providers to maintain, track and use multiple identification numbers as assigned by the various health plans they bill. The NPI replaces those identifiers with a standard unique identifier.

The rule becomes effective May 23, 2005, and most providers required to submit standard electronic transactions under HIPAA must obtain and begin using the NPIs in standard transactions by May 23, 2007. The exception is small health plans, which will have until May 23, 2008, to comply.

Providers need not apply for NPIs at this time, CMS has said, but will receive information on the application process closer to the effective date. ▼

Study: Providers getting better terms

The balance of power between health plans and providers has stabilized during the past two years, with hospitals and other health care providers securing more favorable contract terms, according to a recent study by the Center for Studying Health System Change in Washington, DC.

This is the case despite the fact that contract negotiations have remained tense during the period, notes the study, which examines health plan-provider contracting trends during 2002 and 2003 in 12 nationally representative communities. The report can be found at www.hschange.org. ■