hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

October 2004

beyond the numbers

Navigating the Perfect Storm
A Hospital CFO's View of the Industry

BY ANDY STEFO

INSIDE:

I don't want to ruin the end of the book, but for those of you who didn't see George Clooney in the film "The Perfect Storm" – he wasn't able to accomplish this feat. As I pull myself away from day-to-day crises and details of hospital operations, I am cognizant of and sensitized to the position in which Chicago Metro hospitals now find themselves. Certainly not all issues apply equally to every provider, but there is a convergence of adverse industry problems, the likes of which we have never seen, consolidating and gathering energy – the Perfect Storm scenario.

When we look at the revenue side of hospital operations, there isn't a great deal of positive news. While some infrequent increases have been or are scheduled to be implemented by CMS, the overall future of the governmental sector is grim. A massive Federal budget deficit, an underestimated and under-funded pharmacy drug benefit, and a growing Medicare population segment, all lead to one likely outcome: cutbacks in Federal payments to providers. We won't even begin to speak to the issues at the State level. For those of us still in the psych business, the shoe drops in the very near future.

On the managed care front, significant relief came in the last several years in the form of real rate increases. But for those of us who have been around the block a few times, we know this will be a short-term fix, and the press's coverage of escalating health care costs bears witness to this fact. Employers will be pushing back. There is limited upside here.

As if pricing problems weren't enough, hospitals have the continuing issue of loss of profitable services, led largely by physicians. Physicians' problems are just as real as ours and they will continue to branch-out into ancillary services. Reduced reimbursement and escalating malpractice premiums are squeezing their margins to the point where many physicians have

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Inside This Issue

President's Message

This year again we are fortunate to have the Board of Directors, Committee Chairs and member volunteers, a group of highly motivated and talented individuals active in our Chapter. It is because of these leaders, we have been able to continue to offer great educational programs to our members in the areas of Information Technology, Reimbursement, Revenue Cycle, Medical Group and Physician issues, Managed Care, the CFO seminar, and of course the annual golf outing. Many of us look forward to attending these chapter programs to keep well informed of current issues and emerging trends. For me, the anticipation of gaining insight to current trends pertaining to our industry is exciting, not to mention the networking opportunities of discussing issues with my peers and industry leaders.

Our educational programs devote a whole day to key topics:

- Information Technology, (September 23rd),
- Revenue Cycle (November 18th),
- Accounting and Reimbursement (January 13),
- Medical Groups and Physicians (February 17th),
- Managed Care (March 24th)

Our member responses from the last few years have shown that we provide great educational programs. There exists a multitude of opportunities! Our team cannot be sustained unless we encourage our members to become active with HFMA.

The commitment of our Board, Committee Chairs and members that foster teamwork and professional relationships bring added value to the chapter. The First Illinois HFMA Chapter's service to our members is dependent upon the individuals who have the desire to share their talent.

We welcome new members who bring with them new ideas which provide different perspectives thereby assuring our future growth. Each of you, at every career stage, is invited to participate in one or more of the Chapter's committees - and it is not too late for this year! Please refer to your new 2004-2005 membership directory for contacts or visit our website at www.firstillinoishfma.org . Take the challenge and get involved!

Martin D'Cruz
HFMA First Illinois
Chapter President

beyond the numbers

Reminder - new program location
The November 18th Revenue Cycle program and the January 13th Accounting and Reimbursement program will be held at
William Tell Inn
6201 Joliet Road
Countryside, IL 60525

First Illinois Chapter News, Upcoming Events & Committee Updates

CFO Committee

The CFO Committee has had a busy fall season. To add value to members' participation the committee is trying to provide more educational programs at its monthly meetings geared toward the CFO. The August 13th meeting included a presentation by Mark Heuer, Principal & Portfolio Manager from Harris Investment Management, titled "Enhanced Cash Investing". The September meeting was devoted to planning topics for future committee meetings as well as the May '05 classroom session. The October/ November meetings are scheduled to have presentations on the Community Benefits Act and Strategies for Dealing with the Uninsured and Underinsured. Meetings are held the 2nd Friday of every month at HFMA national headquarters in Westchester. If you would like to get on the CFO Committee mailing list send an email to Guy Alton at guyalton@stbh.org .

Managed Care Committee

The First Illinois Managed Care Committee started the year on September 17. The Committee selected a monthly meeting time for the third (3rd) Friday of every month at 7:30am, in the Boardroom of the HFMA Office in Westchester. The Committee will not only plan the 2005 Managed Care Conference, but during several of the monthly meetings a special guest speaker will be invited to provide a 15-20 minute talk on an important managed care topic. Ken Maginot, Partner at Mercer Human Resource Consulting will be with us on October 15 to discuss employer healthcare benefit issues and current employer trends; other speakers will follow at our monthly meetings. Please reserve a spot on your calendar for this and future special presentations. For more information, contact committee chairs Todd Anderson at todd.anderson@ahss.org or Phil Kamp at pkamp@valencehealth.com.

Medical Groups and Physicians Committee

The Medical Groups & Physicians Committee will begin planning during October for our Feb. 2005 meeting. As usual we will try to be ahead of the curve and present discussions which are timely, informative and you can be assured that we will not shy away from controversy. There are few controversies our committee hasn't met which we don't "love." If you have any questions or input for the committee, please contact Committee Chair Elaine Scheye at elaine_scheye@thescheyegroupltd.com.

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Got Directory?

By now, you should have received your copy of the 2004-2005 First Illinois Chapter directory. IF YOU DID NOT, please contact Jane Bachmann at (708) 383-1860. Or if you have any address changes, contact Jane so that next year's data is correct.

Founders Merit Award Winner

Brian Sinclair, FHFMA, was awarded the HFMA Founders Medal of Honor at the July Chapter Transition Dinner at the Hyatt Regency. It was a fitting forum for the presentation, as Brian has been integral in all the activities celebrated by the Chapter at this annual event.

Brian joined HFMA in 1979, and has served the First Illinois Chapter in many capacities over the years, including various Committee chairmanships and as a member of the Board of Directors. Brian earned the bronze award in 1992, silver in 1995 and gold in 1999. He currently serves as Co-Chair of the First Illinois Education Committee, responsible for coordinating the educational programs put on by the chapter. Brian also serves as the Founders Merit Award chairman, managing the process by which awards points are tallied and reported to National HFMA.

Past-President Paula Wilke said it well when she presented Brian with the award: "Volunteering your time and talents is not always an easy thing to do. With all of us stressed to the max with job and personal commitments, it takes a special person to give more of himself to an organization like HFMA. Brian has continued to serve on key committees, but even more importantly, he has always been here, helping others to grow and develop within the chapter."

The First Illinois Chapter officers and directors extend their congratulations and appreciation for Brian's long-time support and participation. Congratulations Brian!

First Illinois Chapter News, Upcoming Events & Committee Updates *continued from page 2*

Website Committee

The Chapter's Website Committee is chaired this year by Athena Peterson. The committee began meeting in August to establish goals and priorities for the current chapter year. In Phase I, our top priorities were to secure our domain name, secure credit card safety for online registration and ensure all current functionality and information is current. We have already updated the calendar, officers, and committee chairs information and secured the domain name through January 2009. In Phase II, the committee will work on a re-design of the website to provide additional enhancements and functionality, including an "Announcement" page. In Phase III, the committee will add online voting/ballots and online recruiting and committee selection capability.

If you have questions or are interested in working with the committee, please contact Athena Peterson at apeterson@hfri.net.

First Illinois Chapter Transition Dinner

MORE HIGHLIGHTS ON PAGE 6!

PHOTOS BY CARL WILKE

2003-2004 Officers, Board Members and Committee Chairs
Thanks to all for their hard work! Left to right: Jim Ventrone, Jim Watson, Liz Simpkin, Eleanor Michalek, Dick Bagby, Jane Bachman, Dave Golom, Paula Dillon, Rebecca Busch, Sylvia Sorgel, Elaine Scheye, Brian Sinclair, Katherine Lenhart, Marianne Staidl, Janet Blue

First Illinois Speaks Newsletter Committee
The 2003-2004 newsletter committee of Mike Nichols, Liz Simpkin and Jim Watson receives the Yerger Award for Member Communication.

Is your hospital doing all it can to identify underpayments?

BY CATHY A. PETERSON

The average hospital is paid about 10% less than their contracted rates by insurers. Capturing this income would increase most hospitals' bottom line by more than 50%. (The average hospital has net revenue of about 35% from non-government payers and an average net income of 4%. Assuming net revenue of $100 million, a 10% increase of $35 million would yield $3.5 million, an 87% increase in net income.) There are a variety of actions that hospitals can take to capture this lost income:

(1) Systematically identify underpayments;
(2) Avoid underpayments by modifying billing procedures; and
(3) Collect more of the underpayments.

This article focuses on the first issue above: systematically identifying underpayments.

Systematically identify underpayments

Most hospitals identify underpayments by comparing the expected payment they have loaded into their systems to the allowable on the explanation of benefits. This is a critical action to take, but is not enough.

To maximize the ability for a hospital to identify underpayments there are usually four areas that need enhancement:

(1) Designing the insurance master so that all appropriate insurers, products, and payers are included; the correct contract is attached; and the correct address and electronic ID is attached;
(2) Assuring that registration and pre-verification staff can consistently select the correct insurance master option;
(3) Enhancing the accuracy of the expected payment formulas; and
(4) Identifying systematic insurer errors.

Enhance the Insurance Master

Enhancing the Insurance Master and registration staff's knowledge has many benefits. With an updated Insurance Master, registration staff can select the correct insurance company, product, and payer. If they select the correct option, then the hospital can readily:

- Calculate expected payment and thus identify underpayments and avoid inappropriate write-offs;
- Send the claim to the correct place and cash flow will be enhanced and days outstanding will decrease;
- Obtain the necessary pre-authorizations and avoid claim denials and/or financial penalties;
- Accurately determine the importance of the insurer and product for contract negotiations; and
- Avoid unnecessary rework.

Yet most hospitals have error rates on their insurance master of greater than 15%. This leads to lost income because the expected payment will not calculate accurately for these claims.

Most hospitals have error rates on their insurance master of greater than 15%

Below is a list of typical errors with the Insurance Master.

1. ***There is no "insurer" included in the option, when there should be one.*** This is one of the most common error types. If there isn't an insurer included when there should be, then expected payment is rarely attached to that option. For most hospitals in Illinois, over 10% of their patients come from organizations that act as repricers, such as PHCS, First Health, CCN, BCE Emergis, MultiPlan, and Preferred Plan. These organizations do not ever pay a claim. They determine the price for the payers based on the contracts they have with the hospital. Their logos are usually on the insurance card, but the organizations that pay the claim usually have a more dominant logo and therefore it is common for the option to exclude the repricer.

> "Most hospitals have error rates on their insurance master of greater than 15%."

2. ***The insurer is wrong.*** There have been numerous acquisitions of insurers over the last 5 years. Over time the insurers replace the old name with their own. For example, Unicare bought Rush Prudential, so there should not be any Rush Prudential options in your insurance master. Similarly, Great West has stopped using the One Health Plan name, and should no longer appear in the insurance master.
3. ***The contract attached to the insurance option that determines the expected payment is the wrong one***. This error occurs for several reasons. One reason is that many of the insurers have product names that do not specify if it is a PPO, POS, or HMO product. If the hospital's rates vary by the product type, it is difficult to determine the type of product. For example, Blue Cross and Blue Shield of Illinois has a product that on the card says "Blue Choice". If the hospital's contract varies by product, then it is important that it be attached to the POS rate.
4. ***The option does not have a contract attached that would calculate expected payment.*** Without the contract attached, expected payment does not calculate. Sometimes this occurs because there is an option that is a catchall for insurers. For example, some insurance masters have an option called "Commercial" and hundreds of patients are attached to this option. If they were all non-contracted insurers then one could attach expected of 100% of charges. This however, is rarely the case. How often is someone running a report to determine how many options have this problem?
5. ***An insurance product is not identified but needs to be because expected payment varies by product type.*** This is a challenging problem because there are often more products than the insurer may tell you about, the names are often similar, and the product names change frequently. For example, UnitedHealthcare has 3 products with the name "Select" in them. If the hospital's contract varies by product, then it is important to identify each of the product names uniquely in the insurance master. The "Select" products range from EPO, to HMO, to POS.

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Is your hospital doing all it can to identify underpayments? (continued from page 4)

6. ***The claim address and/or electronic ID is wrong.*** This will delay payment or may even cause a denial in payment. For example, HMO Illinois cards always have an address of Blue Cross on the card. If the hospital has a contract with the IPA/PHO identified on the card, a claim for an outpatient service should go to the IPA/PHO. If the IPA/PHO does not receive the claim within 90 days of the date of service, it may deny the claim.
7. ***The payer is no longer with the insurer and yet the option is still included on the insurance master.*** Most hospital systems do not have a separated field for the payer, so it must be included with the insurer name. However, the payers often switch between repricers. It is useful to hide the option that is no longer valid so that the claim will not be sent to the wrong place and if a patient presents an invalid card, it can be identified quickly.
8. ***There is insufficient detail in the insurance master option for registration staff to accurately select the correct option.*** For example, many hospitals have one option for Blue Cross & Blue Shield PPO. This would be incorrect if they have a "Plan" contract because they need to be able to identify whether the card was from Illinois or another State, and if from another state, whether the employer had bought the Blue Card Plan. If it is from another state and the employer doesn't have the Blue Card program, the correct rate would be the Plan rate, not the PPO rate.
9. ***Multiple insurance companies are on the card, yet only one is listed as an option.*** This is the case on about 10% of insurance cards from non-governmental payers. The challenge is if there isn't an option for the registration staff to select that shows multiple insurers, how do you know which insurer is primary and which contract should be attached? For example, if a hospital does not have a contract with UnitedHealthcare, but does with BCE Emergis, then many of the UnitedHealthcare claims would have the BCE Emergis rate applied because their logo is also on many of the cards. (The claim would also be processed out of network, even with a contract.)

Ensure Registration staff is able to select correct option from the Insurance Master

If registration staff cannot systematically select the correct insurance company, insurance product, payer and/or claims address, this will lead to expected payment being wrong and/or claims being sent to the wrong address. Additionally, it leads to much rework. Many patient accounts directors estimate that it takes about 45 minutes on the back-end to fix each error.

Yet selecting the correct option is a significant challenge. There are no standards on insurance cards, thusThe insurer, product name, and address to send the claim can be placed anywhere on the card and are often hard to find. The product name is likely to be unique to the insurer and also may be initials Finally, there may be multiple insurers on the card, and their logo or name may be very small.

Additional factors exacerbate this challenge. Registration and pre-verification staff receive minimal training on the variety of cards and how to select the correct option, and there is usually a high turnover of this staff. There is always pressure to get patients registered quickly, and as we know, patients don't always have a card or present their current card.

Because of the challenges, it is especially important to train the staff regularly by showing them at least 100 of the most common insurance cards. It is also important to testing the staff to be sure that they have absorbed the knowledge and to retest every 3 or 4 months.

Without training, the error rate in selecting the correct option is usually greater than 20%. If you are in doubt, give the staff a test. Show them 50 insurance cards and have them select the correct insurance option.

Without training, the error rate in selecting the correct option is usually greater than 20%. If you are in doubt, give the staff a test.

Enhance the accuracy of the expected payment formulas

Contracts have become increasingly complex. It is very common that there could be multiple contract terms under which one inpatient stay could fall. For example, if a there is a carve-out for a DRG at a percent of charges and that DRG also hits the high dollar stop loss (which pays a lower % of charges), which rate applies? Additionally, there are multiple formulas for implantables, drugs, outpatient groupers, and combinations of outpatient services.

The difference in how an insurer can interpret the possible scenarios can significantly impact the amount the provider will receive. Additionally, this will cause claim problems because if there isn't explicit agreement between the hospital and the insurer during contract negotiations, then the expected payment formulas for the hospital and the insurer are likely to vary. On some contracts there could be over 40 formulas. Isn't it best to reach agreement on the formulas prior to the contract being signed?

Identify systematic insurer errors

If either the hospital or the insurer loads the contract terms into their systems late or in different ways, this will cause systematic claim errors. If the error is the insurer's, the hospital staff usually appeals most of the claims. However, in most instances, the insurer will continue to deny the appeal until someone at a senior level at the insurer is made aware that the contract has been loaded incorrectly. This often requires the involvement of the hospital's contracting staff.

The best way to systematically identify these errors is to download the paid claims and do an analysis by insurer of the key contract terms. That way, the errors are very obvious and the hospital can then get the claims reprocessed in a group.

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First Illinois Chapter

Transition Dinner

PHOTOS BY CARL WILKE

On July 22, First Illinois members gathered at the Hyatt Regency in downtown Chicago for the annual Chapter Transition Dinner. The Transition Dinner is a great way to celebrate the achievements of the previous chapter year, and kick off the new year. We enjoyed pre-dinner socializing, a delicious buffet dinner, and after-dinner entertainment.

If you weren't able to make this year's dinner, plan to be there next July!

Welcome!
The hard-working registration team of Janet Blue, Victoria Thomas, Marianne Staidl, and Michelle Holtzman greet Eric Tate with a smile, a name tag, and of course, drink tickets!

Enjoying the evening
Jerry Jawed and Tonya Hawkins enjoy the pre-dinner networking hour

Hold that thought
Rebecca Busch; Mike Nichols; Ross Stebbins, and Bob Smallwood interrupt their conversation for a photo

Passing the gavel
Past President Paula Wilke congratulates incoming President Martin D'Cruz, while Suzanne Lestina and Jim Ventrone add their best wishes.

Now that's funny!
Entertainment was provided by a professional magician and our very own comedian, Jim Ventrone.

2004 HFMA Information Technology Conference

BY LARRY KLOC

Panel discussion: Eric Tate, moderator. Panel left to right: Daniel Witkowski, Dr. Jim Thompson, David Printz, Joe Auriemma, Guy Mansueto, Mollie Torbik

The first of this season's programs was conducted on Thursday, September 23. The program was titled Information Technology: Enabling the National HealthCare Agenda and was presented by the Information Technology Committee at Aramark in Downers Grove. Healthcare providers, consultants, associations and vendors convened and conversed about industry-government-governance issues and technological responses.

Mike Cohen, committee chairman and healthcare technology consultant established the theme with his introduction by saying that National Healthcare expenditures can be reduced by 10% – a savings of $131 billion –with the creation (augmentation) of an efficient health infrastructure. Noted in Federal programs is to ride the wave of momentum and to C-A-R-E

Mike Cohen, Committee Chairman

Mike Cook, Speaker

Create a strategic Plan
Align with your community
Require openness and interoperability (most emphasized)
Encourage innovative approaches to funding, design and process improvement.

Kathy Vermoch, Project Manager for University Healthsystem Consortium (UHC) presented the results of a study of 35 medical centers' Decision Support Systems (DSS). This project was first suggested by the UHC Chief Information Officer Council that questioned whether centers are using the systems effectively to generate change.

Overall, the critical success factors include strong executive support for the use of DSS to achieve an information-driven culture; significant DSS resources are needed to maximize return; extensive education and training is required to access, understand and use DSS data; to ensure physician buy-in, include physicians in planning processes, identify physician leaders and track patient outcomes before and after implementing changes; and standardize terms, implement data audits and quality checks, fully document reports, and ask end-users for input to enhance data quality and acceptance.

Many respondents identified significant savings with some indicating payback within 1 1/2 years. Other creative results include modeling volume/utilization needs for facility planning and Certificate of Need, developing intermediate care units where ICU units had been used exclusively to reduce costs and free-up access to ICU beds.

DSS offers information on the confluence of financial and clinical data. This powerful tool is underutilized by most, but the enormous potential of Quality Improvement initiatives compels us to more fully utilize DSS.

Jan Hertzberg, Engagement Manager for Jefferson Wells presented a session on IT governance in Healthcare. Growing challenges from regulation include HIPAA, Sarbanes-Oxley, and JCAHO. Senator Charles Grassley has proposed to extend some forms of compliance under Sarbanes-Oxley to not-for-profits. CIOs, executives and management need to evaluate the design and operating effectiveness of internal controls, disclose controls, significant deficiencies and weaknesses, and disclose acts of fraud. Not-for-profits need to consider the Control environment, assess risk, create controls and an anti-fraud program, strengthen the internal audit function, and address key vulnerabilities in information systems.

Michael Cook, Principal of Cardinal Consulting and author of "CFO Survey—ROI on IT Investments" (First Illinois Speaks, August 2004), spoke of the Elusive ROI. There are difficulties in quantifying anticipated results even though several methods are used. The final thought delivered was the most telling:

If not Measured … can't be Rewarded
If not Rewarded … won't be Delivered.

We were urged to rethink the ROI methods, assess readiness for key projects and review results. Successful implementations are completed where the culture of accountability is strong.

James E. Thompson, MD, and Medical Director of Informatics and David L. Printz, CIO spoke of the advanced Electronic Health Record (EHR) Central Dupage Health has put into place. Their impressive demonstration showed how a commitment to technology has resulted in browser-based applications integrated into portal and mobile devices with robust security.

The glimpse into the future continued with presentations from Daniel Witkowski of Sprint, Joe Auriemma of Siemens, Mollie Torbik of Microsoft, and Guy Mansueto of Allscripts Healthcare Solutions who each had brief demonstration of their organizations' product offerings.

In the panel discussion that included Dr. Thompson and David Printz, and the four listed above, two main thrusts are expected: governmental policies on financial and clinical record requirements and consumer demands for efficiencies and efficacies.

Investment in IT will continue to grow. What we learn to direct, measure, finance and implement is augmented by our interactions with our peers. Please attend the First Illinois Chapter presentations – the quality of information and contacts are valuable.

Larry Kloc is Controller, Near North National Group. He can be reached at LKloc@flash.net

Physician Portals:

Offer immediate value to your medical staff without a huge IT budget

BY BARB WENER AND BARB O'CONNELL

Environmental Factors

There has been significant press coverage within the healthcare industry of how hospitals are managing Information Technology demands. The hospital industry views technology on a go-forward basis as a means to an end for patient safety initiatives, improving cost efficiencies, and providing more advanced management reporting capabilities. But hospitals have always had to manage IT issues because of the volume of processes, workflows, and care management tools requiring technology infrastructure. Hospitals have also historically understood the financial commitment these systems require.

The issue of technology is especially important to physician practices these days, driven partly by a need to "catch up" but also by more pragmatic reasons, like the fact that many payors are now eliminating paper transactions and forcing physicians to access the payor's portals for a variety of information and transactions. Electronic Medical Records (EMRs) are a buzzword in today's industry, but with little common understanding of what an EMR is, what is does, and how the connections to and from an EMR work. Most hospitals, medical groups, and physician practices have a long-term commitment to EMRs, but there are many other technology applications that have utility between now and the time that the industry does migrate to an EMR-based platform. One such application is a physician portal.

Doing it for the doctors

Dealing with technology can be complicated for physician practices, especially smaller practices. Doctors are being bombarded by technology options for many of the processes and workflows in their offices. The volume issue is starting to present itself to physicians, as are the financial considerations that come with converting volumes of perhaps antiquated workflows into an automated medium.

There has been considerable dialogue at Rush North Shore about how we best approach technology with our medical staff. The technology issue is a two-way street: If the hospital is going to implement an EMR, it has to be one that the medical staff has helped select and one that they will use. We recognized that the technology challenge wasn't limited to selection of an EMR as part of a long-term strategy. Both the hospital and the medical staff wanted something more immediately to help the doctors with the growing demands of multi-site care delivery. One day we were talking with some of the doctors, and the topic of "portals" came up. We did some research and found that a physician portal was a tool that could be utilized in a variety of ways, and was in fact a growing technology application between hospitals and physician practices.

Putting the Portal in Place

Rush North Shore convened a committee of physicians and hospital IT staff, and worked with Deerfield-based Denmac Systems, Inc. to discuss options and develop a plan. An advisory panel of 15 doctors was involved in every step of the design and implementation of the portal. Once the portal was rolled out to all physicians, the advisory panel physicians played an important role by serving as internal champions in promoting the benefits and convenience of the portal.

Denmac designed and implemented the portal, and the Citrix MetFrame Access Suite was selected as the underlying portal technology because it met the key business requirements of anytime, anywhere access to both web-enabled and legacy IT applications. The Citrix Password Manager was used for single sign-on functionality, and Denmac recommended using this single sign-on capability in conjunction with RSA token authentication. Physicians use either a hard token or a soft Palm token (for Palm Pilots) to generate a secure key that is used during the login process.

The Rush North Shore Physician Portal went live in April, 2004. The portal provides physicians with remote access from anywhere in the world to patient specific information such as lab results, radiology results, patient demographics, insurance information. Doctors can view radiology images, and can review, edit and electronically sign dictated reports. The portal also provides access to meeting minutes, physician rosters and other medical reference tools. Surgeons use the portal to access the hospital's surgery schedule.

Feedback, Usage and Enhancements

The portal has been in place for about 5 months, and its usage continues to spread. At first, things went a little slow, as with any new technology application. Communicating the existence of the portal and its value to the physicians was no small task with a medical staff of 400 doctors. So far, 148 doctors have signed on and we continue to spread the word. Among the 148 that have signed up, the usage rate varies, but as with any IT implementation, there are "early adopters" who start to use the technology and become consistent users. "Once I started signing off on dictation electronically, it became a habit to do it all the time because the old way seemed obsolete. And it's much more convenient to use the electronic signature capability through the portal" says Dr. Jack Morgan, an internal medicine physician. The most consistent feedback we get is that the portal is a time-saver. Time is a precious com-

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modity for doctors, and the portal allows them to increase efficiency by doing things remotely that that formerly had to do in their office or at the hospital.

Like most IT-related projects, we were inclined to want to put an ROI on the implementation of the physician portal; but service goals, rather than ROI, became the most important factor in deciding to move forward. "Even though this project was technology-based, it was never viewed internally as an IT project. It was a project to improve service to our customers" says Jeff Rooney, Rush North Shore's Chief Financial Officer. "Hospitals are always doing things that take more time from doctors. We wanted to give it back. Some of our doctors are saying it saves them an hour a day or more. That hour is critical, especially for our primary care physicians. But almost as important, it's been a way for the medical staff and the hospital administration to collaborate on IT to produce tangible benefits for doctors. It will help enormously in gaining physician support as we move forward on bigger projects."

And that may be the thing that we remember most about this process: Working with our doctors to develop something of value to them from us. The portal was initiated and implemented for, with and by staff physicians. It was also the first step into the technology waters for some of the doctors; we specifically remember one doctor shouting at the first meeting "I don't know what I'm doing here! I don't know a monitor from a mouse." That doctor is now one of the early adopters of the portal.

We have already begun planning for enhancements to the portal's functionality. We have also looked at how to maximize the interactions between the portal and the hospital's website. According to a survey in VARBusiness Magazine (an IT periodical), 48% of hospitals surveyed indicated that they will use their hospital websites to allow physicians access to patients' clinical information, 44% will use it for supply purchasing, 30% will use it for cross-clinician communications, and 31% will use it for transactions with payors.

Clearly the industry is on the front edge of migration to electronic media. Many questions remain: How will physician portals connect to and interface with EMRs? Can we develop a secure access for patients to get at some of the information on these portals that are specific to them? How will all the emerging payor portals integrate over time? Can portals be used as billing and payment interfaces? The list can become overwhelming, and we believe that we've just scratched the surface on moving forward together with our medical staff into many new and useful IT applications.

Barb O'Connell is Director, Information Systems, at Rush North Shore Medical Center. Barb Wener is Director, Physician Relations & Practice Administration at Rush North Shore Medical Center. She can be reached at 847-933-3905.

Avoiding Cost & Clinical Bias in the Acquisition of Drug Therapies

Recent study highlights new role of financial leaders

BY: F. RANDY VOGENBERG, R.PH., PH.D. AND LEO K. LICHTIG, PH.D

Ongoing changes in the healthcare industry have led to an evolution in the role and responsibilities of hospital financial leaders. As advances in medications continue to increase, the corresponding cost of acquiring these medications also increases, as does the challenge of providing the best clinical care in the most efficient and effective manner. Clinical staffs, in consultation with financial staffs, need to collaborate in the development of drug purchasing strategies that will:

- Minimize selection bias based solely on cost or perceived need for use of new therapies regardless of cost;
- Balance clinical and financial demands; and
- Take into account the total cost of care — not only the acquisition cost.

The constant pressure caused by drug price increases has made it necessary that CFOs become more informed and involved in the drug purchasing and acquisition process relative to the demands on financial resources. Traditional approaches in determining which medications to acquire have been limited due to inconsistent, incomplete or even inaccurate data. Decisions, therefore, were made with a built-in bias. An alternative to eliminating bias is to use a methodology that evaluates more costly medications in the appropriate context of overall cost and the impact on the quality of care. When based on objective quantifiable data, the result of an integrated clinical and financial approach to drug selection and procurement will be greater cost savings overall and better patient outcomes.

CEI: An integrated clinical and financial methodology for drug acquisition

One such method of assessing a healthcare organization's drug purchasing cost/ patient outcomes is a process developed by Aon Consulting's Life Sciences Consulting Practice known as the Clinical Effectiveness Initiative (CEI). This process uses a methodology that assists organizations in quantifying the cost and benefits of today's medications that have the potential to be the true "miracle" drugs of the future. CEI focuses on assessing existing therapy alternatives and providing benchmarks for evaluating newer drugs as they become available.

The CEI process was first studied in 2002 at Atlantic Health System in Morristown, New Jersey. The study focused on the treatment of hospitalized patients with or at risk for deep vein thrombosis (DVT), the formation of a blood clot in a deep vein in the leg which can lead to a potentially lethal embolism in the lungs. DVT was chosen as the focus because of new data revealing the growing prevalence of DVT, the high incidence of mortality and the under-diagnosis of the disease. It's estimated that 2 million Americans are affected by DVT annually. According to a newly published risk assessment model (RAM), immobilized inpatients over 40 years of age with acute cardiac and respiratory diseases, cancer, sepsis, inflammatory bowel disease, sciatica, stroke and paraplegia were at significant risk to develop DVT. Despite these risks, studies indicated that a majority of hospitalized patients don't receive DVT prophylaxis, presenting a significant potential liability for clinicians and hospitals.

Using data from 1999 to 2003, 15 hospitals in 2002 through 2003 implemented the CEI process that weighed the use of Low Molecular Weight Heparin (LMWH), a newer medication for the treatment of DVT, against Unfractionated Heparin (UFH), which is the traditional method of treatment. Although each hospital had a system for evaluating care processes, they often lacked comprehensive, system-wide data about the total cost of care of one therapy versus another. One of the participating hospitals included Provena St. Joseph Medical Center in Joliet, Illinois.

The first step in the CEI process, Data Collection and Analysis, was to gather and analyze readily available patient clinical and billing data from information sources, such as the hospital's Medicare cost report, the UB-92 claim form, and pharmacy information system to compare the costs of different inpatient drug treatments. At the participating 15 hospitals, the total cost of care was compared for similar patients receiving either UFH or LMWH. Savings (reduced costs) and losses (increased costs) were analyzed by key cost centers such as Medical/Surgical (Acute), Pharmacy and Laboratory, for various patient categories relevant to the prevention and treatment of DVT 9e.g., long-stay medical patients and hip replacement patients) and by individual diagnosis related groups (DRGs).

Simultaneously with the Data Collection and Analysis phase, stakeholder interviews were conducted to help hospitals identify areas where clinical procedures and costs could be improved. Stakeholders included physicians, pharmacists, quality management personnel and nurses, each of whom provided information on the procedures they followed when identifying, preventing and treating DVT. Additionally, hospital financial personnel and administrators were interviewed to identify areas for minimizing costs and improving quality.

At the conclusion of the CEI process, each institution was provided with a report summarizing the data analyses and stakeholder interviews for their respective institutions. In keeping with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), hospitals do not receive reports by individual physician or physician group; but a hospital can use the database to pinpoint its own physician-and patient-specific information. The report provided hospital stakeholders an opportunity to see and understand the clinical results and financial impacts of various therapies. This report was a useful tool and provided objective evidence from which the hospitals could gain buy-in from key stakeholders, if needed, changes in therapies and acquisition strategies when necessary.

Understanding the real costs

A key finding from the 15 hospitals that participated in the CEI process in 2002 through 2003 was that while financial leaders understood the cost to

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> "While financial leaders understood the cost to acquire drugs... they were unaware of the associated costs of delivering the drugs."

acquire drugs to prevent and treat DVT, they were unaware of the associated costs of delivering the drugs. For example, UFH cost less than $1 a day to acquire. However, it requires multiple lab tests per day, and puts greater demand on nurses' time to administer the intravenous doses and continuously check on the dosages. These delivery costs added substantially to the cost of the drug therapy. Alternatively, the newer thrombosis drug, LMWH, cost about $26 a day to acquire and typically requires dosing only once a day, with no lab testing or IV administration. Thus, this therapy could be administered with reduced nursing care and other expenses, which more than offsets the acquisition costs for most types of patient care. Additionally, savings may come from a combination of shorter lengths of stay, reduced laboratory expenditures, and fewer adverse medication events.

Key financial results

Results were compiled in late 2003, with data collected and analyzed from the 15 participating hospitals that covered more than 720,000 hospital discharges. The results indicated that on average, the 15 hospitals had already saved $560,000 ($536 per case) and had the potential to save an additional $210,000 per year (or $155 per case) by using LMWH instead of UFH. Most importantly, the CEI process helped to highlight the differences between drug acquisition costs and total patient care costs.

Over the past decade, the health care industry has struggled to find innovative ways to secure the necessary resources to maintain its competitive edge and continue to finance the new therapies required to provide quality patient care. As cost and quality pressures continue to mount in today's healthcare arena, financial leaders should work more closely with hospital clinicians to take a more active role in managing overall costs and improving clinical outcomes. By implementing an evaluation process such as the CEI process, hospitals can avoid the purchasing "tug-of-war" that often occurs among financial leaders and clinicians with access to an analysis of their own hospital data that provides analysis of drug medication acquisition costs and overall total costs and outcomes. When based on quantifiable data, the result of this more integrated clinical and financial approach will be lower costs and better patient outcomes.

For additional information on the CEI project, please refer to the following published articles:

Weinberg R., Vogenberg, F.R., Lichtig, L., DeSantis, V. **Optimizing Financial Performance Through Clinical Management Improvement and Risk Management**. *Healthcare Financial Management*. 2004: July.

Weinberg R., Vogenberg, F.R., Lichtig, L., Knauf, R. **Measuring Clinical Effectiveness Using Common Hospital Data.** *Pharmacy & Therapeutics*. 2004: May.

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Navigating the Perfect Storm (continued from page 1)

experienced sizable reductions in year-over-year personal income. Their answer: take the profitable ancillary services in-house. While I have only personal experience and anecdotal evidence, this can lead to excess utilization; something that CMS has yet to realize.

Unfortunately, that's the financial "good news". The expense variables are even more onerous. While a great deal has been written about the nursing shortage, we haven't seen anything yet. I'm not sure what the average age of your nursing staff is, but suffice to say, we have about 6 to 8 years to figure this out, or we'll see a situation that will defy description. I don't see an adequate response from nursing schools. With this type of a supply shortage, I also don't see salaries moderating anytime soon. But what happens when there are no nurses regardless of the wage we're willing to pay?

Probably the next expense line under the greatest pressure is insurance. I have heard on more than one occasion that Cook County has taken over the number one position as the worst jurisdiction for adverse malpractice judgments. If the exodus of insurers from the market is any barometer, this would affirm our dubious distinction. Unlike the past, however, we are also seeing physicians leave the market due to an inability to secure coverage. This may further erode our shrinking revenue base.

Next is the emerging issue of bad debts. With greater patient out-of-pockets and a growing uninsured segment, this will catch many providers by surprise when not managed aggressively. Some hospitals that have seen their bad debt exposure double year-over-year (e.g. Tenet). We also have the potential for consumer directed health plans, which are a quagmire for administration. Then there's all that press about discriminatory practices by providers against the uninsured. Better be careful!

And what about supplies? It seems that despite best efforts in the management of the supply chain, costs continue to increase; and where will all of the technology and drug advancements take prices?

For those of us with variable rate debt, we have enjoyed sunny days for quite a while. However, hold onto your seat; Greenspan is taking rates higher. Factor in the need for capital investment (our suburban hospitals are 30 – 40 years old now) and this expense only grows. That's assuming you have access to capital.

That's pretty much the entire income statement. Then we can add things like regulatory requirements (medication errors, HIPAA, etc.), politics at the state level (e.g. Certificate of Need), the aging of our physician staffs, and things couldn't look better! So you throw up your hands and say "What am I supposed to do? I'm only the CFO!"

It seems to me that we need to look outside of our industry "thinking" and a little at history itself. We're not the first industry that has confronted external forces that are screaming for change. Manufacturing went through it 20 years ago, led by off-shore competition. The financial sector is still experiencing its change. Maybe we should be looking to learn lessons from these industries instead of repeating our mantra that "health care is different."

When something in our society reaches the point of actual or perceived crisis, a certain bureaucracy in Washington seems to step in. My sense is that we're creeping closer to this scenario every day. I don't think that's the best solution, and I think history also bears this out. Experiments in national health care in other countries have had mixed results at best, and the medical research and development advances continue to largely source from the United States. So what do we do? If we do nothing, it will be done to us by Washington, and that means all health care providers, including physicians.

> "As CFOs, we constantly hear and read about methods to make our facilities more cost-efficient. However, I would suggest to you that we must revisit our operations utilizing a fresh perspective. When we take a step back from the details, it becomes clear that we work in a very personalized service business. Do we know our markets? Where do we make and lose money?"

We have to approach our situation with a two-pronged attack. Since we're already being buffeted by the edge of the storm, we'll have to "batten down the hatches." But as the title implies, this is one storm we're not going to ride out. So we have to change "tack" and go around the storm.

As CFOs, we constantly hear and read about methods to make our facilities more cost-efficient. However, I would suggest to you that we must revisit our operations utilizing a fresh perspective. When we take a step back from the details, it becomes clear that we work in a very personalized service business. Do we know our markets? Where do we make and lose money? Anywhere from 60 to 80% of our costs are related to payroll/benefits and supplies/service. Therefore we need to:

- ***Elevate the Human Resources and labor functions.*** We need to elevate Human Resources and labor functions and all of their attendant skills to a much higher level. Do hospitals really know the labor costs of delivering health services? I would venture to say no. If we did, we'd be much more proactive in real-time information and solutions as well as focused on a long-term strategic emphasis concerning our future work force. We should be exploring every way possible to make our employees more productive and in filling the pipeline. This should be the number one emphasis and we shouldn't be comparing ourselves to "healthcare best performers", but look rather to industries outside of our own for answers.
- ***Ditto for supply chain.*** We continually tell ourselves that we're good at this function. The reality is; we haven't even touched this opportunity. Manufacturing and retail (i.e. Wal-Mart) could teach as a thing or two about this area, and it will take some investment in talented people to make the advances that are necessary.

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- ***Create a "culture" of financial accountability.*** Hospitals talk a good game in terms of financial accountabilities, but we really aren't very good at this either. We need systems that give us information automatically, directed towards problem areas. There also needs to be recognition that we're "job order" versus "process" shops, and information must follow this model. We need to know where we make (and lose) money. We have to avoid the delusions that "mission" is our excuse for poor performing or nonstrategic services. We need revenue goals for growth as well as expense control. This will require an investment in middle and upper management, and an orientation towards people who can manage, versus clinicians who are promoted into such positions.

In short, we need to get passionate about revenue growth and cost effectiveness. Now this will get us through some rough seas, but it's not going to keep us from sinking. Therefore, we are gong to have to change course. This means some fundamental changes over old approaches.

Once again, I'm going to refer to other industries that have encountered and survived similar situations. After World War II, the manufacturing sector (and attendant industries such as distribution) experienced incredible growth. In a sense, if you "hung out your shingle", you were successful. Then along came the 1970's. Cheaper foreign competitors, consolidation, etc. came crashing down on this sector. Many companies folded, but some not only survived, they saw this as an opportunity to reinvent themselves and establish their own futures. While the causes for our crisis may be different, the situations are very similar. What were (and are) some patterns of success that we should consider?

> "We have to change 'tack' and go around the storm."

1. ***Place new emphasis on the work force.*** We're going to have to get involved in growing our nursing work force. No one will do it for us. We need strategic investments in key staff positions. Highly effective personnel in HR, Supply Chain, and Business Development are going to cost us money, but they represent 60% to 80% of our income statement expenses and our future revenue growth.
2. ***Adopt real cultural changes that translate into outcomes.*** Mature industries require accountability in the form of great management and a true discipline in business development. Other industries have achieved this. We have to learn from them.
3. ***Rethink our physician strategies.*** The Hospital as "the physician's workshop" model will not be workable in the future. If we continue to operate in customary relationships, the profitable segments of the hospital business will evaporate. This will require concise market assessment, a clear vision and guiding principles to govern these relationships.
4. ***Strengthen the Board of Directors.*** We need Boards that understand our dilemma and can actually add value to strategic direction and relationship development.
5. ***Get serious about political activism.*** We are not "getting the word out".
6. ***Invest in information.*** We need to realize our information systems are in a woeful condition. We under invest, don't demand solutions from primary vendors and have no concept how systems become a key enabler to strategic initiatives. A lot of money is wasted. Yet when you take an objective view of industries that transformed themselves, technology is always at the top of the list of success factors.

Whether we become the "shapers" of the healthcare world of tomorrow or the "adapters" to this world, it's going to take new approaches, fresh ideas, vision and courage.

So what do you think?

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Is your hospital doing all it can to identify underpayments? (continued from page 5)

Conclusion

Hospitals can significantly increase their income by identifying more underpayments. The four key actions to accomplish this are:

1. Improve the insurance master;
2. Train the registration and pre-verification staff;
3. Improve the accuracy of the expected payment formulas; and
4. Identify the systematic claims errors through a database analysis.

Cathy A. Peterson is the President of Peterson Healthcare Consulting, and a member of the First Illinois Chapter of HFMA. She can be reached at 773-580-6800 or cathy.peterson@att.net.

New Members

The Chapter welcomes the following new and transferred members:

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2004-2005 Calendar

11/18	Revenue Cycle	Full Day	William Tell Inn Countryside
1/13	Accounting and Reimbursement	Full Day	William Tell Inn Countryside
2/17	Medical Groups and Physicians	Full Day	Location TBD
3/24	Managed Care	Full Day	William Tell Inn, Countryside
5/06	CFO Meeting	Full Day	Location TBD
5/27	Annual Golf Outing	Full Day	Location TBD

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