



HFMA Today

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Official Newsletter of the North Dakota Chapter of the
Healthcare Financial Management Association

making
connections

Volume 11, Issue 3 August 2008

Presidents Message

by Jodi Atkinson



Presidents Message:

I am pleased to be the President of the ND Healthcare Financial Management Association for the 2008-2009 fiscal year. I have had the privilege of working with the association for about 18 years as a member, Board of Director and currently as an officer.

The Board of Directors and Officers are looking forward to the 2008-2009 year. The Association belongs to you and we are here to ensure that we are meeting the needs of our membership.

The officers attended a training session in San Antonio, Texas in April, the theme for the session was "Making Connections". I would say the theme is two fold. One connection is in your line of work. The educational opportunities that this association provides is the connection you need to provide tools to help you do your job. The second one is the networking and friendship connection. You will find that you will come away with solutions to issues or questions that you may have had prior to coming to the conferences and make a new friend along the way. I encourage you to become involved with the chapter. You will develop a networking opportunity like none other and build lasting friendships along the way.

Please feel free to contact any of the board members or officers with questions. The names and contact information is listed below:

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ADDING LONG-TERM CARE BENEFIT TO MEDICARE IS BEST WAY TO ENSURE AFFORDABILITY FOR FAMILIES, SAY HEALTHCARE OPINION LEADERS

Adequate financing for long-term care, improving the quality of long-term care services, and developing an adequate, skilled workforce are some of the urgent challenges facing long-term care in the future, say four of five respondents to the latest Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey. Nearly four of five (79 percent) respondents favor or strongly favor adding a long-term care benefit to Medicare, financed by a premium, to pay for care.

More than two-thirds (69 percent) of respondents to the survey believe it is very important (41 percent) or important (28 percent) that the health reform plans of the presidential candidates address the quality and financing of long-term care. Opinion leaders surveyed include experts from four broad healthcare sectors: academia and research organizations; healthcare delivery; business, insurance, and other health industry; and government and advocacy groups. Elected officials and media representatives were excluded.

A majority of healthcare opinion leaders say that long-term care costs should be shared by individuals and the government (55 percent), while 26 percent say costs should be shared by individuals, employers, and the government.

BUILDING A NEW PAYMENT SYSTEM

Common complaints regarding the current healthcare payment system are that it does not adequately support wellness, high-quality care, or efficiency, and that it drives up costs with its complexity. But what can be done to remedy these shortfalls?

That is the focus of the Healthcare Financial Management Association (HFMA) report *Healthcare Payment Reform: From Principles to Action*, part of an ongoing effort to foster a new payment system.

For payment reform to be effective, it must take place within a set of principles that support the nation's health goals, as well as support the needs of key stakeholders: consumers, providers, payers, and employers. Such a strategy will best ensure that changes to the payment system result in improvements that can be shared by all stakeholders and any unintended burdens or negative consequences would be minimized.

To this end, HFMA engaged with healthcare thought leaders representing a range of system stakeholders to identify payment system principles, as well as actions needed to make the principles a reality.

The principles that HFMA and the thought leaders identified are:

Quality. Payments should encourage and reward high-quality care and discourage medical errors and ineffective care. Wherever possible, payments should reward positive outcomes, rather than adherence to processes. In the ab-

sence of outcome measures, payment systems should reward the use of accepted practice and evidence-based processes and protocols that meet or exceed standards of quality and safety to promote optimal outcomes. Payers should not be responsible for payment to cover costs directly related to serious preventable medical errors.

Alignment. Payments should align incentives among all stakeholders to maximize the efficiency and coordination of health services based on accepted practice and evidence-based delivery models and protocols. Payment systems should stimulate and reward healthful behavioral choices and selection of value-based services by consumers related to prevention, primary care, acute care, and chronic disease management. Care decisions should be made through a shared decision-making process in which consumers' values and preferences are identified and respected.

Fairness. Payment systems should sufficiently balance the needs and concerns of all stakeholders. Payments should recognize appropriate total costs for the efficient delivery of healthcare services that are necessary and consistent with evidence-based care, high-quality/low-cost provider benchmarks, and the advancement of medical science. Payment systems should accommodate payers' and purchasers' needs to allocate funds in a predictable, manageable fashion. In addition, consumers should have financial incentive to select high-quality, efficient care without being discouraged from seeking necessary and appropriate services.

Simplification. Payment processes should be simplified, standardized, and transparent. Payment and billing systems should reduce the volume and complexity of communications sent to healthcare consumers and the cost of billing, adjudication, and payment for providers of care and payers. All parties should use payment methodologies, standardized at the national level, to reduce complexity. The payment methodologies should be transparent to those affected by them, and comply with privacy, security, and antitrust laws and regulations.

Societal Benefit. The resources needed to support broad societal benefits such as medical and public education, medical research, and care for disenfranchised or uninsured persons should be identified and paid for explicitly. Similarly, payment systems should reward innovators who develop technologies, services, processes, and procedures that enhance safe, high-quality, and efficient care.

To make these principles actionable, HFMA examined potential payment design elements. HFMA then shared some of these design elements with representatives of key industry stakeholders—providers, payers, employers, and consumers—to identify areas of consensus and potential challenges that might arise with implementation.

To read more about these principles, design elements, and areas of consensus and concern, view the report *Healthcare Payment Reform: From Principles to Action*. The report is sponsored by 3M Health Information Systems, KPMG, and McKesson. In September, HFMA will hold its 2nd annual thought leadership retreat on building a new pay-

ment system, which will bring together members of various healthcare stakeholder groups to further define how the payment system can be designed to accomplish the nation's larger health goals.

Any initiative on payment reform must incorporate Medicare, which has been moving toward value-based purchasing. HFMA's Medicare Payment Forum provides regular news and tools related to Medicare's payment changes.

HOW WELL ARE YOUR SERVICE LINES DEFINED?

The appeal of a service line strategy is obvious: growing patient volume through market differentiation while limiting costs and improving outcomes through targeted efforts. Yet all too often, healthcare systems fall short in realizing the strategy's full potential.

One of the most common reasons is that the organization fails to appropriately define the service lines, as noted in "Measuring Service Line Success: The New Model for Benchmarking," an article in this month's hfm magazine. Without this focus, duplication and fragmentation often begin creeping in.

To improve your organizational understanding of ser-

vice lines--and ultimately, have a starting point for determining those that will warrant investment--authors Tara Tesch and Alexis Levy from Navigant Consulting recommend keeping in mind several guiding principles:

Service lines are patient centered. Programs that will reap the most benefit are those that involve care delivery at sites across the entire care continuum. In traditional hospital management structure, care is organized by skill (lab, imaging, medicine, surgery) or by facility (physician office, hospital, outpatient center, nursing home). In contrast, a service line model should place less emphasis on where care is delivered and more on the care's coordination; patients should be able to access the service line from any point in the care continuum.

Under a service line model, the hospital should be looking for opportunities to create protocols, standardize processes, and leverage IT so that the patient experience is consistent regardless of where care is delivered. Furthermore, as a greater proportion of care is provided on an outpatient basis and with value-based incentives from payers to keep patients out of the hospital, addressing health care from this continuum approach is increasingly important.

Patients can identify with the service. In addition to this patient-centered orientation, the service line needs to be the reason that the patient is seeking healthcare services. For example, patients understand that they have a cancer diagnosis or a heart condition, or need a joint replacement. Other functions such as imaging, lab, and rehabilitation are provided in support of the service lines; for example, a patient receives rehabilitation services because he or she had a hip replacement, which would fall under a potential musculoskeletal/orthopedic service line.

Coordination of services improves quality and efficiency. Service lines should be focused on programs that can make a meaningful impact on the organization not only from a financial perspective but also based on quality and outcomes measures. An organization should take the time to quantify the potential "lift" it could gain from investing in a service line in terms of margin per market share point or additional outpatient procedure performed, as well as understand how difficult it would be to obtain that incremental business.

Services can cut across different sites of care, but simply because a service is delivered in multiple locations does not necessarily mean it is a service line. In some instances, services may represent supporting businesses that benefit from coordination and centralization, but are not necessarily patient centered. A lab is an excellent example of a service that benefits from centralization across a system; however, lab services are driven by clinical programs or services lines--for example, a patient needs lab work due to a specific diagnosis.

Once service lines are defined, hospitals can better focus on measuring their success. Similarly, measuring performance of a service line must foster prompt decision making. Therefore, data must be accessible, understandable, and reliable. That means having the appropriate information systems and knowledgeable

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support staff that can cull information and present it in a format that's easy to understand. All decision makers within the service line need reliable information to make sound decisions and effect change. More information about selecting service line performance indicators can be found in HFMA's educational report *By the Numbers: Using Data for Optimal Service Line Management*. The report is sponsored by MedAssets.

PHYSICIAN ADOPTION OF ELECTRONIC HEALTH RECORDS STILL VERY LOW

Despite the promises it offers health care and quality improvement, only a small minority of U.S. physicians have embraced electronic health records (EHRs) as a routine part of practice, says a study report in the June 19 online edition of the *New England Journal of Medicine*. The survey of 2,758 physicians shows that only 4 percent have a fully functional EHR system and 13 percent have a basic one.

25 MILLION ADULTS ARE UNDERINSURED; NUMBER UP 60 PERCENT IN FOUR YEARS

The number of underinsured adults rose by 60 percent between 2003 and 2007, from 16 million to more than 25 million, according to a new Commonwealth Fund study released June 10 as a Health Affairs web exclusive. Middle- and higher-income families were hit the hardest by the steep increase: Underinsurance rates nearly tripled for those with incomes above 200 percent of the federal poverty level (annual income of \$40,000 or higher for a family).

HOW CAN YOU TRAIN PHYSICIANS IN CLINICAL DOCUMENTATION?

Helping physicians dot the I's and cross the T's in clinical documentation has never been more important, as new coding rules are changing the definition and calcu-

lation of payment and external groups are comparing and contrasting the performance of individual providers, point by point, according to a recent HFMA educational report entitled *Improved Documentation: Leveraging Staff Training, Benchmarking, Technology, and Process Change for Accurate Payment*, sponsored by 3M Health Information Systems.

Concurrent documentation programs rely heavily on training physicians about the demands for greater specificity in their documentation, not only to adhere to new Medicare coding rules but also to provide an accurate picture of their patients for outside profiling agencies and to point out that the documentation that works in the private practice environment doesn't always translate to the hospital setting.

But formal departmental meetings go only so far.

"In any given hospital system, a departmental meeting will capture only about half of the physicians who need to be involved. So you can't just do that and assume everyone will know what's going on," says Marion Swaim, vice president of health information management at the seven-hospital Sentara Healthcare system in Norfolk, Va. Sentara's concurrent documentation program takes advantage of forums such as grand rounds and subspecialty meetings, and it targets physicians' assistants to help physicians understand why they are being asked for more information.

Early on, the program named a senior medical staff leader as a co-administrative leader of the project, and it made the vice president of medical affairs the point of contact for physicians at each site. The vice president of medical affairs not only helps to introduce the concurrent documentation program to physician specialties, but also works one-on-one with physicians or specific physician groups on the purpose of the program.

Typically, a second wave of support comes from clinical documentation liaisons or specialists—the frontline staff who deal directly with physicians on a day-to-day basis to identify what's in the medical record and, more important, what's missing.

At Sentara, nine of its 19 concurrent documentation specialists are either registered nurses or licensed practical nurses. The specialists work with physicians to replace implied with explicit medical detail, clarify diagnoses that are present on admission, and add descriptors that precisely define a condition or procedure.

The system employs coders who have more than five and closer to 10 years of experience, and it assigns one or more to work in a specific hospital depending on the needs of the facility.

The government's Recovery Audit Contractor (RAC) initiative is one area where accurate clinical documentation is having a direct effect on hospital payment. As this initiative moves from a three-state demonstration program to a nationwide effort by 2010, hospitals must ensure that documentation in all billable services completely and accurately reflects patient status and services provided.



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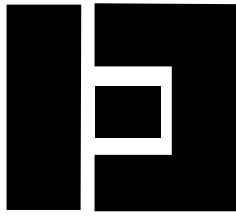
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