hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

November 2003

hfma: it's personal

INSIDE:
A Tribute to Robert M. Shelton
Past President of HFMA

How to Get Your Business Associate Agreements Completed "The Battle of the Forms"

By Steve Marshall, MBA, CHFP

This short article will attempt to give you a framework or a 'methodology' for completing the Federal Privacy requirement to have Business Associate agreements (BAA) in place no later than April 14, 2004. This writing will not be an explanation of all the elements that have to be included in a business associate agreement. Please seek legal advice for this. I also want to be clear that this is written from the viewpoint of a provider. However, vendors can transpose the roles to gain clarity for those entities that 'fit' the business associate agreement definition in relationship with healthcare providers. Most of what I am suggesting we have learned through trial and error. I want to be clear that this is NOT legal advice but is a process that an organization can use to assist in gaining control of a cumbersome element in the Privacy Rule.

The Privacy Rule requires that a Covered Entity (CE) obtain assurance from its Business Associates (BA) that the Business Associate will safeguard protected health information (PHI). These assurances must be in writing. Hence the business associate agreement form was created.

A Business Associate in its simplest definition is an entity that performs work on behalf of a Covered Entity, usually gets paid for the work performed and in this work has access to the protected information. (There is an exclusion for Medical Equipment Suppliers except in the situation where they are training the workforce and at the same time need access to PHI to do that training. This is a complicated area in which you should seek advice).

Some common examples of Business Associates are: claims processing services, data analysis, legal, actuarial, accounting, consulting, software companies, accreditation and financial services.

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Inside This Issue

President's Message

Turning of the Seasons

As I write this, the trees are losing their leaves, the air has turned cool, and the days are growing shorter. The wonderful warm colors of fall are disappearing and the cold winter months are coming into view. This is the time of year that makes some of us more reflective and sometimes even a bit blue. This year, the seasonal transition from fall to winter is made all the more poignant because it coincides with the passing of Robert Shelton, a founding member of HFMA. Bob had already retired when I first met him in the late 1980's. I would see him again and again at HFMA events. He always greeted me by name and with a smile. I was intrigued as to why he had stayed so involved with HFMA even during his retirement. When I asked him about this, the answer became obvious. He simply loved it! His enthusiasm for HFMA and his interest in helping others develop in their career was genuine. He urged me to get involved as a volunteer with the chapter many years ago, and I am glad I did. At the Leadership Training Conference this past April, Bob congratulated me on my upcoming year as President. His words of encouragement that day gave me confidence that I would serve the chapter well. You will read about Bob throughout this newsletter and if you did not know him, you will get a sense of his many contributions to HFMA and how he personally touched many in our chapter. Bob drove a car with the license plates "Mr. HFMA" and that says it all.

Time marches on and we will honor Bob best by keeping his legacy of HFMA alive. With his passing, the next generation, you and I, must step up and assume the responsibility of encouraging others to get involved in HFMA. It is our turn to be there to share our knowledge and experience and support the younger members. This passing of the torch became real to me at our revenue cycle education session in October.

I invited the newest member of my management team to attend the meeting with me. It was a wonderful experience for both of us. I observed her take it all in - the learning, the networking and the sharing of knowledge. I had to smile when she chased down one of the panel members to trade business cards. She came back and enthusiastically told me she had secured a site visit to that hospital to see first hand how they had implemented point of service collection. Watching her reminded me of everything I love about being a member of HFMA. She emailed me the next day and wrote, "just wanted to tell you how much I enjoyed the seminar. There was a lot of great information that brought some things together for me. It also really re-energized me as far as next steps." She went on and outlined what she wanted to implement based on what she had learned that day. What a powerful testimony to the value of HFMA!

So, although we are sad with the passing of our friend, Bob Shelton, we must be thankful for his legacy of HFMA, and we must continue in his memory to mentor those who will come after us. The seasons will continue to change; winter will pass into spring.

Farewell, Bob. And thank you.

Paula Wilke
President
HFMA First Illinois Chapter

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First Illinois Chapter News, Upcoming Events & Committee Updates

Information Technology Committee

The Information Technology Committee will present: "Optimizing Your I.T. Advantage: an Industry Update" on Thursday, November 20, 2003 at Maggiano's Little Italy in Oak Brook. The program will address:

- What are the current trends in adopting health care information technology?
- What's next for HIPAA after the privacy and transactions deadlines have been met?
- How are providers justifying IT expenditures and gaining benefits from the investments?
- How can strategic IT planning help improve IT performance?

Managed Care Committee

The committee's focus for the past couple of months has been on planning the Spring 2004 Managed Care Seminar, to be held on Thursday, March 25, 2004 at the Carlisle in Lombard. We have lined up a nationally renowned keynote speaker to kick-off the session with a discussion on current healthcare trends and issues. Two panel discussions are planned on two cutting edge issues: Technology and Its Impact on the Health Care Delivery System, and Quality: The Movement Towards "Pay For Performance". We will also have a Legislative Update from Springfield, and a presentation from a Chicago hospital CFO on how he integrated managed care contracting into the revenue cycle management process at his facility.

The committee is seeking sponsors and exhibitors for the seminar; please call Jim Watson at 630-571-6770 if you have any interest.

Medical Groups & Physicians Committee

The Medical Groups & Physicians Committee is now planning its February 19 all day program to be held in downtown Chicago at the law firm offices of Gardner Carton & Douglas. Count on a day of not only very good food for thought but good food as well. There will be e several reasonable parking options – details in the program announcement. As usual, the committee does not shy away from controversy, so you can expect that we will include topics and speakers who think outside the box. We hope to see you on Feb. 19.

Hold the date!

REGION 7

HFMA Region 7 Symposium
Oct 21-22, 2004,
At the Hyatt Regency in Downtown Chicago

The HFMA Region 7 Chapters (Illinois, Wisconsin and Indiana) are sponsoring a symposium on health care financial issues unique to our region. Come hear prominent speakers and meet your colleagues from around the Midwest, all in a convenient downtown location. Special room rates will be available if you wish to stay overnight, or through the weekend. Watch for more updates through the year.

For more information, contact Martin D'Cruz at (317) 338-6877

Getting Serious About Asset Management

By Don Dovgin

Who borrowed the monitor from the ER, and did not return it? When did you last see that infusion pump? Where did you lose that abandoned wheel chair? But most importantly… WHERE IS IT NOW? These questions are commonplace in hospitals as they attempt to keep track of their equipment.

The pressures of regulatory coupled with never-ending rising costs have created a fury of frustration and chaos in the healthcare marketplace. This has driven the need for a more effective tracking solution for equipment, inventory, materials and workflow. Asset Management Tracking (AMT) is new technology that provides a competitive advantage for organizations that plan to adopt it. Conventional hospital management systems have minimal capability in the way of asset tracking. They require costly paper and bar coding for most processes, and the success and accuracy of these systems are limited and questionable. Today, new asset tracking technology has pioneered a seamless management solution that delivers instant visibility in real time.

Using technologies driven by wireless tags, fixed position antennas and web-enabled software, AMT provides visibility with proven efficiency and operating returns. Through perpetual monitoring of the unique wireless tag signal, AMT can pinpoint any item's exact location 24 hours a

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Special December Program!

Revenue Cycle Impacts under HIPAA:
An Operational Focus
Day Egusquiza, President, AR Systems Inc.
Tuesday, December 16, 2003
The Carlisle in Lombard

While HIPAA regulations continue to be revised, health care financial leaders should prepare and then adapt their plans as final regulations are released. It is important to identify steps for "HIPAA Alerts" within the revenue cycle.

- What should you look for in the new standardized submission process?
- How do you anticipate handling the ongoing privacy issues?

This program will provide invaluable hints tips for developing action plans!

Day Egusquiza, President, AR Systems Inc.

A nationally recognized speaker with over 25 years experience in health care reimbursement, business office operations, contracting and compliance implementation. If you did not hear her speak at ANI, don't miss this chance to see her right here at home!

Multiple I.T. Paths to Address Medical Errors

By Michael R. Cohen

A hospitalist at a prominent teaching hospital was bold enough to publicly share the details of an actual medical error incident. An infant was brought to the emergency room accompanied by his mother, and treated by a senior medical resident. The patient was given a dose of medication 10 times the generally recommended dose for a patient of that age and weight. There were no serious complications, but the doctor immediately recognized they had dodged a bullet. Though he was not on duty at the time, the physician was the attending MD of record, and the resident was operating under his supervision. Noticeably shaken by the incident, he took it upon himself to objectively investigate the root cause of the incident. What he discovered was a series of errors and a breakdown in the system of manual checks and balances that is used at many hospitals today. Specific errors he uncovered are:

1. The registration system had the wrong birth year, computing the patient's age as 12 months too old. This made the higher medication dose look more reasonable to anyone not knowing the true age of the patient.

2. The patient's mother informed the medical staff that the patient was currently being treated with a drug on an outpatient basis, which she had with her. She emphatically stated the dose. It was later discovered she was wrong. The outpatient/retail pharmacy did not have dosing instructions affixed to the home medication. They were handed out separately and not brought with the patient to the ER.

3. The resident did not check safe-dosing guidelines. He ordered the home medication, at the dose specified by the mother, to be administered on the floor.

4. No route of administration was specified.

5. The ordering nurse did not check safe dosing.

6. An inpatient pharmacist questioned the dose, but it was at shift end and no one followed-up.

7. The administering nurse did not check safe dosing guidelines.

Bottom line – at least 7 people could have intervened to avert the error, but did not!

Obviously concerned about the breakdown in the manual system, the doctor began looking for solutions to the problem.

Different Solutions and Approaches Abound

If you were faced with this situation, you would have a number of alternative paths to consider. Here are a few:

The hospital described above had success following a low tech short-term solution with plans to move into a more information systems intensive solution as money becomes available within the next 2-3 years. Using common sense and the leverage that comes from working with residents in a teaching hospital, they decided a reasonable solution was to mandate (and enforce) more complete manual orders. With little cost, they designed new order sheets, and required the following data to be completely and accurately filled in for each order:

- Patient Name
- Dose per KG weight
- Route
- Interval
- Indication for ordering the drug

This simple solution has had very positive results in the first few months of implementation in a pilot unit. Incomplete orders were reduced by almost 50%. By assuring all the appropriate information was readily available for the ordering physician and any other health care professional reviewing the order (attending MD, pharmacist, and nursing) the manual checks and balances already in place were working much more effectively. While they hope to get more automated assistance, eventually leading to a Computerized Physician (or Provider) Order Entry system (CPOE), they are happy with their first steps, and learned valuable lessons they can apply to future CPOE implementation.

CPOE

With the current attention being given to patient safety, especially medication errors, many providers investigate CPOE as a high priority option. While there is no generally agreed upon definition of such systems, they can be characterized as sophisticated information systems aimed at having the direct care provider personally enter key clinical orders (pharmacy, lab, radiology etc.) directly into the computer. Ideally, the order will include clinical edits and alerts to assure the order is appropriate based on patient diagnosis, clinical information and prior orders/medications for the patient. Some providers even include financial edits, such as disclosing an option for a less expensive medication, test or procedure that has been demonstrated to be clinically equivalent. These are often part of a larger, integrated set of clinical systems, and may have many other features such as charting, clinical notes, bar coding, medication administration etc. embedded in them. Such systems have tremendous promise of reducing errors and improving the quality and cost effectiveness of care. There are many such products on the market today, but less than 5% of hospitals and physician offices have deployed them. Major constraints to growth are high cost, difficulty getting physician acceptance, and the lack of clinical standards, though these barriers are gradually being diminished.

Order Entry/Results Reporting Clinical Information Systems

For providers still relying primarily on manual orders, an intermediate step between manual systems and CPOE is to implement an order entry/results

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Multiple I.T. Paths to Address Medical Errors (continued from page 4)

reporting clinical system. These systems are characterized by the ability to electronically enter clinical information and orders, as well as perform a host of additional information storage, communications and analysis. Such systems have been available and productively used, especially in hospitals, since the late 1970's. According to the Dorenfest Market Share Report over 85% of US hospitals over 100 beds already have order entry/results reporting systems in place. The biggest drawback to such systems in the medication error scenario is that they are typically geared more towards use by nursing and office staff than by physicians. Even so, they can be very effective in securing accurate orders, checking for incompatibilities between drugs (as well as with diet, lab etc), and having key clinical information available when needed. When tied to decision support tools, they can also be used to determine appropriateness of care, cost effectiveness of ordered medications and tests, and outcomes analysis. While difficult to document and prove, many experts believe prudent implementation can lead to significant cost and length of stay reductions.

Electronic Medical Records

Electronic medical records (EMR); also frequently called Electronic Health Records (EHR), Computer-based Patient Records (CPR), Automated Patient Records (APR) and more, have been the holy grail of medical informaticists since the 1970's. The concept is simple – have virtually all patient information that may be needed for caregivers available in electronic form. This has the potential to virtually eliminate many of the inherent problems of manual paper records; such as illegibility of orders/notes, lost or missing records, the ability for the chart to be in only one place at a time, and the high costs of chart storage and duplication. EMR's are typically considered a more advanced and sophisticated application of the order entry/ clinical information systems described above. In fact, it is not uncommon for vendors to have a migration path to upgrade older systems to an EMR. Further blurring the lines of distinction between the continuum of products, many believe that CPOE systems are most effective when bundled or embedded into an EMR.

Niche Solutions

The solutions described above are generally most effective when highly integrated with other clinical systems and deployed throughout the health care provider organization. Depending on the specific problem you need to address, there are a variety of niche solutions available. Here are a few:

- Bar Coding is frequently used within the medication cycle to enforce the mantra of right patient (bar code the patient wrist band), right drug and right dose (bar code the drug label) and right time. As a by product of use during the medication administration, it also helps create an accurate and complete automated medication administration record. The same technology can also be very effectively deployed in many other clinical and non clinical areas of the organization
- Pharmacy only physician order entry solutions are available, many of them using portable units such as PDA's. They can be effective in dealing with certain medication errors and often have instantaneous prompts and alerts for the ordering physician.
- Document Imaging can be an effective tool to eliminate some of the inherent problems of paper records, such as storage and accessibility. Several hospitals have won the prestigious Davies award from the Computer-based Patient Records Institute (CPRI – now part of HIMSS) for achieving excellence in health care quality, cost, and accessibility through the use of an EMR, by basing their EMR on this technology. When combined with the work flow management tools that are available with many of the higher end products, they can also be very effective in simplifying the number of steps, and cost in routing information throughout the organization.
- Robotics can be very effective in handling many of the labor intensive production tasks in large, high volume pharmacies, reducing labor costs and pharmacist errors in filling and dispensing medication.
- Highly specialized products are available for use in specific clinical processes. For example, there are products specifically designed for maximum value in cardiology, to decrease potential medical errors with infusion pumps, or for use exclusively within ICU/CCU.

In many ways, health care information technology is still a cottage industry. For example, there are over 450 companies claiming to offer an EMR. You need to clearly define and understand the problems you are trying to address. Depending on your needs you can implement a comprehensive integrated systems solution, a more limited solution, or a highly specialized niche product. In some cases this can come from an upgrade to your current systems. Depending on your needs and your budget, a manual solution focused on modifying work flow and documentation requirements, may also solve your problem. Let's not minimize the importance of process changes. Regardless which solution you embrace, the implementation and ultimate success is going to be highly dependent on tailoring the system, revising work flow/processes and managing the change process.

(Mike Cohen is president of MRC Consulting Group, and he can be reached at 630-653-9242)

www.FirstIllinoisHFMA.org

Have you checked the website lately? This is your one-stop source for all kinds of chapter news and information. Features include:

- Committee chairs and officers directory – who to call, how to get involved
- Calendar of Events and upcoming program announcements – see the hot new topics and speakers
- Online registration – save time and register by email (sorry, no credit card processing yet)
- Newsletter archives – find that great article from a past issue

The Website Committee is working hard to provide more features and functions all the time. Frank McHugh (chair), Morley Kerschner and Athena Peterson have volunteered to help bring our Chapter communications into the 21st century. To learn more, or join the committee, please go to the website and choose "Contact Us" to send an email.

The Battle of the Forms (continued from page 1)

Some common misunderstandings about who is a Business Associate include an organization that is providing a 'patient treatment' and doing its own billing. An example of this would be an ambulance service that the healthcare organization shares information with while each has a Covered Entity treatment relationship with the patient.
The most common question is whether a contracted janitorial service is a Business Associate. In most every case the answer in 'no' as the work performed does not require access to PHI. At times you have to fully understand the nature of the business relationship and the information flow to know whether this relationship/ requirement exists.

Now comes the fun.
You must collect information throughout the organization to create an 'inventory' of your potential business associates. This information can come via accounts payable records, contracts and a survey of leadership. The inventory is the starting point for making the decision as to who is and is NOT a Business Associate.

You have to narrow the listing to those entities that fit the definition of a business associate. We identified five (5) scenarios that may play themselves out as follows:

- A clear Business Associate relationship exists based on the rule and the definitions, e.g. legal, clearinghouse, consultant. In these situations the Business Associate acknowledges the relationship and agrees to sign a business associate agreement.
- Departments within the Covered Entity may be functioning as a Business Associate of another Covered Entity (i.e., providing answering services to independent physician practices or providing MSO services). In this situation the Covered Entity is required to flip flop its role and be a Business Associate for another entity. (Based on the risk to the Covered Entity, the business associate agreement terms and the nature of the services, the Covered Entity may decide not to continue to provide those services that define them as a business associate).
- A clear Business Associate relationship exists whereby the provider is the covered entity and the business associate expects to have the covered entity sign its form. (The issue here is whether the terms are adequate and how much risk is being shifted back to the Covered Entity/provider.)
- An outside entity may misinterpret the HIPAA rules and submits a business associate agreement for signature to a Covered Entity. (Executing a business associate agreement in this situation may expose your organization to unnecessary risk).
- An entity that meets the definition of a Business Associate may ignore or refuse to sign the necessary business associate agreement .

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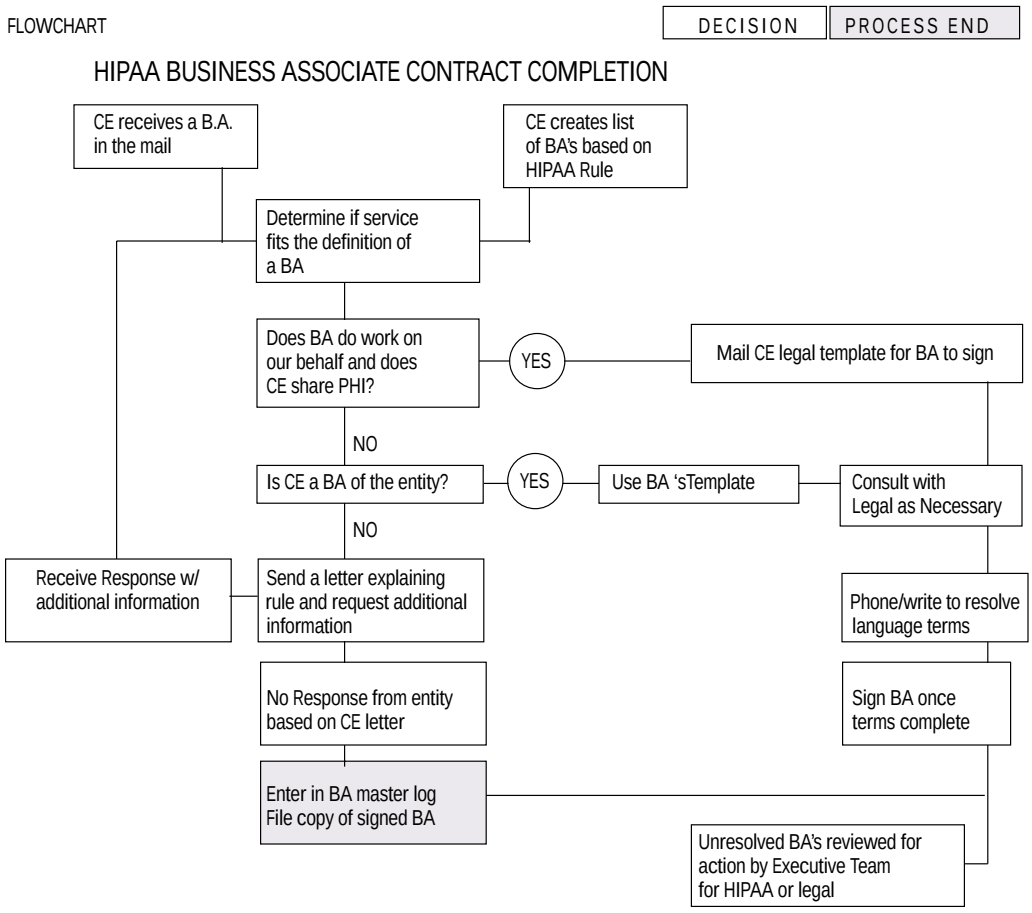
The Battle of the Forms (continued from page 6)

Below is a rudimentary flow chart that illustrates a process for working through these five (5) scenarios:



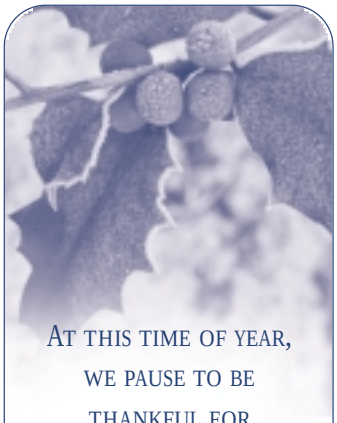
The business relationship typically determines which model template is the basis of the negotiation. In essence, the party that has the 'perceived' leverage within the relationship is usually able to influence the terms and which form is used (i.e., The Joint Commission accepts no modifications to its business associate agreement and will only work from it's template).

One could argue that whichever entity is the Covered Entity has the requirement to comply and that the Business Associate should work in good faith from the Covered Entity's template. However, in practice this has not been the case. In cases where an impasse develops, privacy officials may need the guidance of legal professionals or their executive team members.

Summary

At present, most organizations in healthcare completed the implementation of the Privacy Rule and have now turned their attention to implementing Transactions and Code sets by October, 2003. Although there is considerable activity in the business associate area it will be a significant accomplishment to complete this work with all entities by the compliance date. Some large organizations may believe that the exposure is to great to enter into a business associate agreement since the government's regulatory authority does not extent past the Covered Entity. The rule specifies that the Covered Entity must terminate the business relationship if the Business Associate does not sign a business associate agreement by the compliance date. As a practical matter, this may not be possible as healthcare systems may not be able to financially afford the change over or may simply run out of time. Expect that Health and Human Services will issue additional guidance to move the industry to compliance.

(Steve Marshall is the Corporate Director for Patient Financial Services and the HIPAA Program Director for Central DuPage Health System, and he can be reached at 630-933-6308)



AT THIS TIME OF YEAR, WE PAUSE TO BE THANKFUL FOR OUR FAMILIES AND LOVED ONES. WE ALSO REMEMBER THE SPECIAL RELATIONSHIPS WE SHARE WITH OUR COLLEAGUES, THROUGH ORGANIZATIONS SUCH AS HFMA. THE FIRST ILLINOIS CHAPTER WISHES YOU A JOYOUS HOLIDAY SEASON AND HAPPY NEW YEAR!

A Moment in Time

Dear Bob,
I wish I had a moment in time to tell you all the things our chapter accomplished this past year and how proud you would be of our work. I wish I had a moment in time to share with you how the members and leadership team of the First Illinois Chapter excelled in their commitment to make this chapter even stronger than it was before. I wish I had a moment in time to tell you how much youíve inspired me.

I remember the first time I met you and I thought you were just a nice man that had been around for many years. Later, you stopped me and introduced yourself and told me a little about the history of HFMA and the role you played in the creation of the association. I was intrigued. I met you a few more times at social functions and national conferences and we chatted some more. I met your lovely wife Ethel who is just as spirited as you. I learned more about what went into the growth and changes of HFMA. I looked forward to the next time I would meet you and have the opportunity to talk.

I will always remember a special moment in time. It wasnít the 3rd time I met you, or the 4th time, it was just a moment when you and I were talking and you glanced around the room and observed all the HFMA members that were there representing both national and chapter leadership, working together to ensure the quality, value, and future of HFMA. And you said with pride, "This is my future this is my legacy; this is what we put in motion years ago to ensure that HFMA would be around for many years and it all comes down to these people, this room and what they can accomplish together."

The vision of yesterday has become the reality of today. Your guidance and inspiration has helped us to achieve our successes. Thank you for taking a moment to let me see HFMA through your eyes, the possibilities, the accomplishments, and the future. How appropriate that the current national chair, David Canfield, chose "it's personal" as his theme, because you made HFMA personal for me.

We have enjoyed the pleasure of your company for many years; you will be missed. If only I had one more moment in time.

Suzanne Lestina

Remembering Robert Shelton

It is with deep sadness that we say goodbye to Robert M. Shelton, FHFMA, CAE. It's impossible to measure how much Bob has meant to our association - as a past voluntary and staff leader of HFMA, he has influenced us in countless ways. Many HFMA members and particularly First Illinois Chapter members knew Bob personally, as he stayed active with HFMA and attended ANI for many years, presenting the prestigious chapter award that was named for him. Bob will be sorely missed.

Robert M. Shelton, Past President of HFMA

Robert M. Shelton, FHFMA, CAE, past president of the Healthcare Financial Management Association (HFMA), passed away on Monday, September 22, 2003, at 12:30 a.m., at age 85. Shelton had suffered a stroke in May. During Shelton's 25 years of service, HFMA grew from a small group of hospital accountants into a respected and influential professional organization of more than 20,000 healthcare financial managers. (HFMA now has more than 32,000 members.)

Shelton began his career in healthcare financial management at Mercer Hospital, Trenton, N.J., where he served as chief accountant. Shelton's tenure with HFMA began in 1950, when he joined the American Association of Hospital Accountants (later renamed HFMA).

The New Jersey chapter of AAHA was Shelton's "home" chapter, and he served as its president. He was elected to the AAHA National Board of Directors in 1956, and for two years served as chairman of the Board's Committee on Chapters. His career with HFMA accelerated in 1958 when he was elected president of the AAHA Board of Directors. In 1959, he was appointed the executive director of the AAHA National office, a position he held until 1978. Following a 1978 restructuring, Shelton became HFMA's vice president. He retired in 1981.

Shelton became a certified Fellow of AAHA in 1957 as part of the first class of members to take the Fellowship examination and achieve certification.

Shelton was awarded the Frederick C. Morgan Individual Achievement Award in 1971, HFMA's highest award for individual achievement. In 1979, to pay tribute to Shelton's many years of service to the Association, HFMA created the Robert M. Shelton Award for Sustained Chapter Excellence, which is presented annually to HFMA chapters exhibiting five consecutive years of sustained achievement.

Shelton's dedication to HFMA continued throughout his retirement. Shelton performed a lasting service for the Association

Bob has been, and will always be my friend. We met in the middle 1980s and when he learned I was from the New Jersey Chapter (at that time) he immediately started grilling me about my experiences in that Chapter. You see, Bob was originally from New Jersey and started his HFMA career there. He had an insatiable curiosity about all things HFMA. We developed a closer relationship over the years and cemented it when I moved to the Chicago area in the early 1990's. Bob was a wonderful mentor to me and I will miss him terribly

– Steven Berger, FHFMA, CPA

I will never forget how, as a brand new HFMA member in 1976, I was approached at a meeting by Mr. Shelton who made me feel so welcome, expressing genuine interest in my young health care career. If I could go back in time, I would love to have worked with Bob in pioneering the HFMA; what an honor and thrill that would have been.

– James Unland

I never saw Bob without a smile. As a past President and a former newsletter editor, I had the opportunity to work with Bob Shelton on a number of occasions. He was always upbeat and never spoke a disparaging word. Bob loved HFMA and he loved sharing his stories about the development of accounting in the health care field and the development of HFMA. Sometimes, as us older folks are prone to do, he would repeat a story a time or two. But each time, the enjoyment he garnered sharing the story shown through. It wasn't hard to understand how Bob could have attained the success that he did. He was a special person. I'll miss him.
– Morley Kerschner, FHFMA

by researching and writing the definitive history of HFMA, From Acorn to Oak, which was published in 1991. And Shelton attended 44 consecutive HFMA Annual National Institutes.

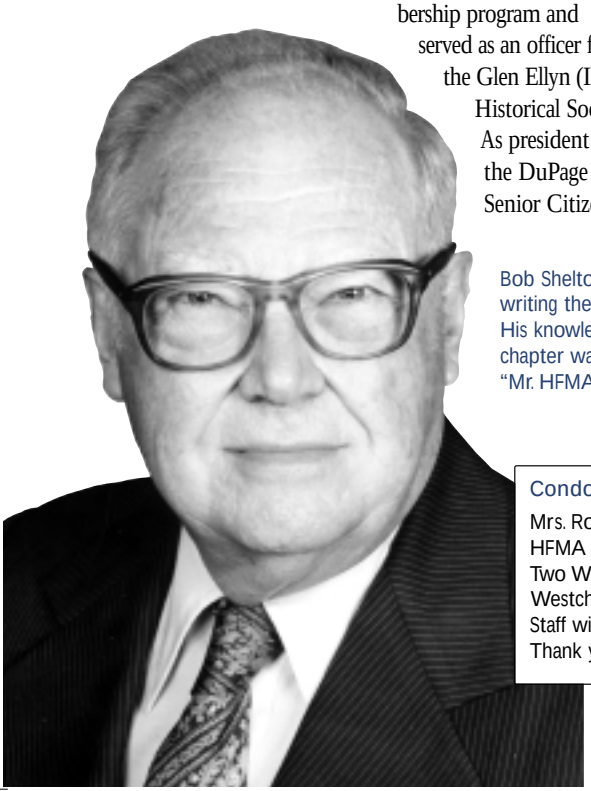
Richard L. Clarke, FHFMA, president and CEO of HFMA, says, "Bob was my mentor, colleague, and friend. His willingness to provide an historical perspective to current issues facing the Association was always helpful and appreciated. I believe he and others of his generation provided a solid foundation upon which a great Association was built. I will miss him."

Shelton served in the U.S. Air Force during World War II and was discharged with the rank of Captain. In 1951 he was recalled to active duty in the Air Force, serving two years as a supply officer in England.

Shelton was active in his community and church. He volunteered his time with the First United Methodist Church, serving on its finance committee and other committees. He promoted a business membership program and served as an officer for the Glen Ellyn (Ill.) Historical Society. As president of the DuPage Senior Citizens Council, he spearheaded a program that uses county funds to underwrite the costs of home maintenance for needy elderly citizens.

Before he became ill, Shelton wrote the following in a letter to HFMA staff: "The song has ended but the melody lingers on in my heart. When I retired, I stated that 'I could not have had a better career had I written the script myself.' What a great career I have had, and what a blessed opportunity to observe the future that I created with the help, of course, of HFMA's thousands of members, its founders, its national and chapter leaders, and the HFMA staff."

Shelton is survived by his wife of 60 years, Ethel, whom he met when she was a registered nurse working at Methodist Hospital in Philadelphia; by his children, Dane Philip and David James; and by seven grandchildren and one great-grandchild.



Bob Shelton and I spent a lot of time together writing the history of The First Illinois Chapter. His knowledge of the years of growth of our chapter was invaluable. His nick name of "Mr. HFMA" was most appropriate.
– Harold Staidl, CPA

For He Was a Jolly Good Fella
Robert Shelton, A Tribute

I can't remember just when I first met Bob, but I do know that I quickly realized he was special.

It became customary that when I called Bob, interspersed with discussing the immediate business at hand would be anecdotes he shared with me about how healthcare evolved into what we know today. I was privileged.

Once, in writing something about Bob, I mistakenly listed his age as 86, when he was only 81. Being a classy gentleman, we laughed about my mistake and it immediately became a standing joke between us and lots of others since he loved to tell the story to them in my presence. After apologizing profusely, I told him that I hoped he would reach and pass the 86 mark, but that was not to be.

The last time I saw Bob we were seated together at Maggiano's during the 2003 Leadership Training Conference meeting. With the unsteadiness of his hands and my recently broken wrist, we made quite a "twosome." In Bobís usual good form, we laughed about our shared infirmity. And heartily we both ate.

To know Bob was to observe first hand how he defined professionalism. Professionalism was not business school vernacular. Rather, he taught it by way of example in how he lived his life. For Bob, it meant love for working within healthcare, dedication to HFMA, mentoring countless healthcare professionals (today well-ensconced in successful careers), integrity, and putting things into proper perspective. His devotion to family and his church took front and center stage. He stopped to smell the rosebuds. Bob, we have much to learn from you.

For he was a jolly good fella, that nobody can deny. Rest in Peace, Dear Bob.

Elaine Scheye

Condolences may be sent to:

Mrs. Robert M. Shelton, FHFMA, CAE
HFMA
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154
Staff will coordinate deliveries of cards to Ethel.
Thank you for your expressions of sympathy.

Donations would be gratefully accepted by any of the following organizations:

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Insights

Can New Jointly Owned Contract Labs Give IPAs and PHOs Purpose (and New Revenues)?

By: James Unland

In their groundbreaking survey of physician organizations,[1] IPAs and PHOs throughout the Chicago area market, Elizabeth Simpkin and Karen Janousek noted that: "*…as HMO enrollment flattens or even declines, and capitation becomes less sustainable for many, physician organizations[1] are reevaluating their continued participation in risk-based contracts, and struggling to define their future roles.*" [2] Among other conclusions was their astute recommendation for hospital-affiliated contracting organizations, in whatever form, to: (a) find value-added services for the participating medical practices and (b) preserve some relevance and purpose for these organizations from the point of view of hospitals and hospital systems who, too often, are standing around wondering what to do with these organizations while, at the same time, trying to keep them afloat financially.

In conjunction with a broader effort to answer hospitals' persistent question, "What can we do to stay relevant and be of use to the docs?" I've investigated and been involved in all kinds of 'jointly owned' collaborations to help 'keep hope alive' in IPAs, POs, PHOs and other contracting federations; unfortunately, however, many of these attempts at reinvented purpose are limited by (a) fraud and compliance regs and (b) physicians' unwillingness to invest capital, a nearly universal physician psychopathology well known to any HFMA member.

Nonetheless, recently the concept of 'jointly-owned but *contracted*' ventures has come to my attention, and one example of this is the rather newly developed concept of the jointly owned *contracted* IPA-hospital laboratory service.

What is it? Why do it?

The concept is to retain a company that is already in the business of owning and operating custom-tailored, *client-specific* labs under contract to medical practices and hospitals. The 'lab company' owns the equipment, employs the lab employees and provides a 'turnkey' service of a specified range/list of tests to the explicitly constituted joint venture.

The lab itself is ideally housed in a physician office building and operated independently of the hospital but with more complex tests going to the hospital's lab—that is, tests not generally performed by the co-owned 'contracted' lab. In other words, the lab itself is *created, capitalized and operated for the express purpose of serving the 'jointly owned' contract to the IPA-Hospital entity* which, in fact, does need to be a legally constituted entity.

In terms of the motivation for doing this: (a) from the physicians' point of view they often send too much lab work out to reference labs, losing potential revenue[3] and (b) from the hospital's point of view physicians often do not or will not use the hospital's lab, and in this new kind of arrangement the hospital could get revenue from performing the complex lab work not performed by the joint venture, work that is too often now going to outside reference labs.

Ownership Structure

A legal entity is either created (in the case of the absence of an actual PHO) or used (in the case of an existing PHO) that memorializes the intent of an IPA and a hospital to collaborate in this venture and the details pursuant to doing so.

Note that little or no investment of capital is required, other than some minimal organizational expenses, because *the lab itself is equipped and staffed by the lab management company, which is contracting with the collaborative entity.* Repeat: no investment in equipment or other major capital is required from physicians, a significant departure from most 'joint ventures' and, historically, a significant barrier to many joint ventures.

The physician entity (IPA) enters into a revenue split agreement with the hospital *within the legal confines of the collaborative entity* (PHO or whatever it is) to split profits from the lab venture itself. Typically this is 50/50, but basically is a negotiable item.

Source of Income

The hospital partner or an independent billing service is usually responsible for billing and collecting for the tests performed in the lab.[4] After payment to the lab management company for its services and for any other expenses (such as space, billing fees, license), the remaining profit is split based upon the joint venture agreement. Depending upon payer mix, lab reimbursement and volume of testing, the gross profit to the JV entity can range from 25% to 40% of collected revenue.

Benefits to Hospital and IPA, Respectively

The interesting departure here appears to be the benefits of this kind of 'contracted' arrangement without onerous capital investment, along with a side revenue spin-off benefit to hospitals of obtaining more advanced tests that are often now sent out by medical practices.

Bob Pellar, President of one of the companies setting up and managing these kinds of lab ventures in the Chicago area, Paragon MedManagement, L.L.C., summarizes the benefits to hospitals and to medical practices: "First, the hospital partner gets the more advanced testing—usually the higher paying tests—to do in their own labs; the joint venture lab will typically perform 85% to 90% of the tests ordered by the

Jointly Owned Contract Labs (continued from page 10)

physicians. Second, the individual medical practices have control over and indirect ownership of a lab in their proximity and no longer have to send tests out to corporate reference labs. Third, the IPA gets net revenues and an expansion of its purpose without a major financial investment."

Is This Legal, and Why?

Properly structured, these arrangements are legal. Here's why: the well-known Stark legislation and related regulations created an exception for ventures between independent physicians with no recognized business relationship and a hospital for the development of jointly owned and operated "Designated Health Services." The Stark statutes have a provision for a so-called "under arrangements" exemption that, in effect, has provided the foundation for, for example, lithotripsy partnerships between physicians and a hospital.

The hospital needs to be a partner in order for the project to fit into the "under arrangements" exception in Stark. When doing the compliance assessment for a project, it is recommended to do the "Stark" review first and then look at the Medicare anti-kickback safe harbors. Once Stark issues have been addressed, the IPA as a joint venture partner—or the PHO as an 'in place entity'—offers an attractive vehicle to address OIG-related issues of compliance with the anti-kickback statute.

In an "under arrangements" project, the cash investment will be real and in proportion to the equity participation, low though those cash investments may be in a 'contracted lab' arrangement. The incentives and benefits flow directly to the IPA and *indirectly* to the individual physician members irrespective of their volume utilization of the laboratory—a crucial compliance ingredient. Thus, *all IPA and/or PHO members get the same benefit from the venture* and, from a regulatory point of view, that is an essential characteristic of properly structured arrangements.

A Rare "Win-Win" Type of Arrangement

Anyone who has suffered or nearly suffered brain damage by trying to get physicians to comply with the 'equal investment' provisions in joint ventures[5] will welcome an arrangement that enables joint ventures but keeps investments quite low. The jointly owned entity that 'contracts with' a business entity such as a laboratory can, if structured properly, be a rare 'win-win' for hospitals and physicians.

In the case of structuring the joint venture contracted laboratory, the hospital can benefit beyond just the confines of the joint venture itself in that it can position itself to perform more complex tests outside the scope of the jointly contracted lab, thus gaining heretofore uncaptured revenue.

Hospitals be warned, however: if you pursue doing these more complex tests, make sure to do them right, be error-free and involve the physicians in addressing concerns that caused them to send their tests out in the first place.

(James Unland is President of The Health Capital Group, and he can be reached at 800-423-5157)

[1] Note: they defined 'physician organizations' broadly, to include IPAs and PHOs.

[2] "*The IPA/PHO Risk Dilemma: A survey of the Chicago Market,*" First Illinois Speaks, Jan 2003 issue.

[3] Physicians often avoid using their own hospital's lab, for a variety of reasons.

[4] A logical argument can be made for the billing to be 'independent' thus removing physician concerns about the hospital having too much control.

[5] To my many friends in HFMA: my recovery is going well !

Steven Berger

Bobette Gustafson and Suzanne Lestina

Larry Connell

Panel members at the October 16th Revenue Cycle Presentation: (L to R) – Greg Wimbrow, Jim Heinking, Berie Encarnacion, Randy Johnson, Mary Furrer, Virginia Martinez

Attendees at the October 16th Revenue Cycle from Northwestern Memorial: (L to R) – Dee Ann Riley, Dan Landsman, Vernita Jorden, Scott Pederson, Elise Lauer, Randy Johnson

Revenue Cycle Program Notes, October 16, 2003

One of the benefits of participating as a corporate sponsor of HFMA is the ability to attend certain programs for no additional cost. I used this opportunity for the Revenue Cycle Presentation on October 16, 2003.

What was the committee thinking when it picked that day? Well, as one of the speakers and the panel members all agreed, if your health care organization was not HIPAA compliant by October 15, October 16 would not matter.

Attendees were treated to an excellent panel discussion on some of the best practices being implemented today for improving cash flow through the revenue cycle. The presenters represented a diverse cross section of the hospitals and health systems within the First Illinois Chapter, and all are "working in the trenches" to get the job done. Any attendee should have gained at least one take-away from the panel discussion; if they didn't they simply were not listening.

It is always a pleasure to listen to Bobette Gustafson and Suzanne Lestina. Talk about passion for your work! These two ladies are the virtual Webster's definition of the term. Bobette and Suzanne discussed the human aspects of the revenue cycle and shared some very relevant experiences, both from the perspective of seasoned consulting professionals as well as consumers within the health care delivery system. I especially enjoyed their demonstration of the true cost of employee turnover.

Steve Berger's presentation in the afternoon gave attendees many interesting and objective benchmarking criteria that can be used within their revenue cycle operations to migrate (at the speed of light) towards best practices. As all of us within health care finance know, any point we want to prove can be done with numbers and graphs. Steve's presentation provided new insight into ways to develop and implement these tools.

Mike Nichols is Director, Health Care, at RSM McGladrey. He can be reached at (630) 588 0450

Gettting Serious About Asset Management

(continued from page 3)

day by using Radio Frequency (RF) devices for tracking. When properly attached, RF transmitters act like homing devices to track all different types of assets. They can be installed on infusion pumps, ECG's, ventilators, cardiac monitors, broncoscopes and hundreds of other types of assets. But how does RFID and more specifically asset tracking really benefit the hospital?

A Laurel research study indicates that a typical hospital carries an average of $3 million to $4 million in hard clinical and non-clinical assets. The same survey also states that most hospitals achieve a mere 57% utilization rate of capital assets. A typical hospital has an inventory of 8 portable clinical devices per bed, at a cost that ranges from $500 for a wheelchair to $15,000 for a respiratory ventilator. Of these, 15% to 20% are missing at any given time. Hard cost for replacing this equipment is $500,000 per year. That, however, is not the end of the story.

Take for example a fully equipped surgical team. Average cost for this clinical labor is $600 per hour. A team minimally spends 10 minutes locating, preparing and assembling their surgical instruments and equipment. For a 12 surgery per day hospital, this wasteful time easily exceeds $400,000. What becomes even more compelling are the lost billing opportunities.

A Recent Washington Medical Study indicates a typical 950 bed hospital employs approximately 300 IV pumps at a cost of $25 each per day. This same hospital keeps 600 pumps on hand at all times to serve their patient population. If all IV pumps can be accounted for at all times, the actual number of pumps needed can be reduced to 330. This represents more than $2 million annual savings for the hospital. This same study also points out that of the 300 beds using the IV pumps daily, less than 150 patients were actually paying the "per day" cost to the hospital because of poor equipment tracking. AMT could help the typical 900 bed hospital recover almost $8 million of annual lost charges.

Another attractive opportunity to healthcare providers is minimizing liability with regulatory standards with HIPAA and JCHAO. HIPAA cites "media controls", articulating guidelines of equipment management and data capture. Because RFID tags act as transmitters, they can send signals back to a computer database to capture information. This allows hospitals to better understand when equipment was used and which patients used them to schedule maintenance. It also acts as a quality control system to minimize equipment decontamination violations, by identifying patient-to-patient equipment transfer problems. These accurate real time records easily exceed the regulatory requirements for these two organizations.

By improving the medical equipment management process, AMT allows healthcare facilities to increase utilization rates and reduce equipment inventory. The system identifies underutilized equipment (which can be sold for cash), reduces capital expenditures and decreases a facility's reliance on equipment rentals. The resulting savings generate a strong return on investment, and the typical healthcare facility experiences a payback period of less than 12 months.

Clinical people at work admit healthcare organizations are quickly realizing the need for good asset management in their workplace. For hospitals that have not yet moved to this type of system, there is going to be an acceleration of progress, particularly in light of HIPAA and overall security. In practical terms the bottom line is smooth business continuity in terms of work flow and information. Most hospitals cannot afford to be down for more than an hour. How long can you afford to be down and how much will it cost just because you can't find equipment?

(Don Dovgin is a partner for the Laurel Group in Chicago, he can be reached at 847-975-8300).

New Members

The Chapter welcomes the following new and transferred members:

Pamela Breider
Director, Managed Care
Swedish Covenant Hospital

Joel W. Busboom
Sales Executive
Johnson Controls

Marjorie A. Clare
Reimbursement Supervisor
Michael Reese Hospital

J. Michael Dean
Director, Managed Care
St. Francis Hospital & Health Center

Michael L. Eckburg
Vice President Strategic Accounts
USCS Equipment Technology Solutions

Heidi Ewell
Vice President
Solucient

Mary E. Grabert

Roy Hart
VP Business Development
MedRemote

Shawn Holt
Assistant Vice President
ENH Medical Group IPA

Patrick M. Hurst
Managing Director
Houlihan Lokey Howard & Zukin

Susan Jones
Senior Manager
Ernst & Young LLP

Paul A. Jordan
Associate Consultant
Deloitte & Touche LLP

Alex Keefe
Student

Patricia J. Klancer
Sr. Consultant
McFaul & Lyons Group, LLC

Michael L. Lauzon
VP of Finance
KSciences

Lisa M. Lenz
Director Revenue Cycle
Children's Surgical Foundation

Kevin J. MacDonald
Senior Reimbursement Auditor
Blue Cross Blue Shield of Illinois

Marie C. Mendoza
Patient Access Manager
Central DuPage Hospital

Heather K. Moon
Consultant
Hewitt Associates

John P. O'Malia
Director of Finance and Administration
Valence Health

Jordan A. Overton
Consultant

Ajay Patel
Chief Executive Officer
Outsourced Medical Services

Gail F. Patinos
Manager Audit and Compliance
Advocate Good Samaritan Hospital

David A. Reitzel
Senior Manager
Deloitte & Touche LLP

Lovin Saini
Student

John R. Sasaki
Managing Director
Huron Consulting Group

Steven B. Schwartz
Regional Vice President
E Appleal Solutions

Douglas J. Vander Linde
Mercer Human Resource Consulting

Chris Wallace
Manager – Revenue Cycle Management
Advocate Good Shepherd Hospital

Jeffrey Worden
Relationship Manager
Harris Trust & Savings Bank

Unclog Cash Flow by Freeing Up Beds:
Brand-new strategy can help hospitals improve revenue and boost patient satisfaction

By Pattie Kloehn

Every hospital financial manager wants to improve revenue performance. Many, however, are overlooking a major jam in the cycle—patient flow.

Problem: Hospitals across the nation report they are filled to capacity and cannot accommodate additional patients.

Impact: Inability to bring in direct admits, transfers, observations and outpatient post-ops means revenue loss. Long waits for bed space mean patient satisfaction scores take a beating.

Cause: Lack of bed capacity? Actually, most hospitals find the problem is tied to inefficient departmental communication. Plus, late-morning discharge policies are largely ignored (patients often don't leave until mid-afternoon, while new admits wait in line). The common reaction from bed control: "We have enough beds—we just can't turn them over effectively."

Solution: Intake Units, Discharge Lounges and Intake/Discharge Centers.

How they work

The basic idea is to take key registration, nursing, bed control and customer service functions, put them all in one place, and give the unit real authority to direct patient traffic.

Imagine an Intake Unit that dispatches consent forms, medical histories, and insurance verification while a nurse performs initial patient assessments, contacts patients' doctors and initiates tests and minor treatments such as pain relief and intravenous fluids. Managing patients more effectively from the time they walk in the door means they often won't require an extensive work-up on the floor, and that makes them more likely to be accepted by a floor.

If space is a problem, a devoted Registered Nurse known as a nurse admissions coordinator can perform these duties on the run, either in the ED or on a floor. Admissions floor work personnel can go to the patient to perform a proper registration in the system so nurses can access patient information and chart on accounts immediately.

Likewise, patients who are ready to leave the hospital can enjoy the privacy of a Discharge Lounge while they wait for a ride home, freeing up a bed that might otherwise remain occupied. The Discharge Lounge's staff can call in prescriptions for patients being discharged or schedule follow-up appointments with their physicians. Patients can enjoy hot lunches and check their e-mail in the lounge, or just read magazines. This also gives financial counselors one last opportunity to make sure all paperwork and insurance information is in order before the patient goes home. If needed, a financial discussion can take place in a private location where the patient is in a more relaxed state of mind, after treatment has been received.

The essentials

Location, Location, Location. An Intake/Discharge Center's success or failure can hinge on its location. Proximity to admissions and the emergency department is desirable. Plus, try to give the space a "club-like" feel.

Centers have failed because they were located in dicey hospital real estate. Putting your Intake/Discharge Center in the bowels of the building may make nurses hesitant to release their patients for discharge. A location next to Admitting—or an appropriate exit area where patients can actually look out the window for their ride—will be an easier sell to your nursing staff.

"Prowling" Is Essential. Waiting for nurses to utilize the center can lead to no use. You can make a world of difference by assigning a clinical specialist (RN) to actively make rounds to identify center candidates.

Give the Unit Authority. The Intake/Discharge Center owns the big picture. Give it the authority to move patients into discharge and prep patients for floor admission. The center needs authority and leadership to change practices in other departments. Staffing the center with volunteers who simply wait

Unclog Cash Flow by Freeing up Beds...(continued from page 3)

for patients to be escorted in will result in minimal usage.

Win Physician Buy-In. Show physicians the big picture and let them see how they contribute to success or failure. Key statistics on discharges and admissions will let doctors understand how missing an 11 a.m. discharge can impact overall hospital flow. Change policy so that a discharge can be performed with only two doctors, an attending physician and a main consultant.

Win Nurse Buy-In. Nurses may resist the lounge idea, feeling you are moving patients out of their comfort zone. Correct this perception by sharing current wait time statistics and patient satisfaction scores that need improvement.

Set the Stage with Education. Educational videos or pre-admission tours can help patients get used to the idea of your center or lounge. When it becomes part of the routine, patients will feel comfortable waiting in the Discharge Lounge for a ride after discharge hours.

"Dress" for Success. A separate Discharge Lounge can feature reclining chairs, private bathrooms and other amenities. An Intake Unit may require private rooms and gurneys. Design your center or lounge to solve your biggest patient flow problems.

Loosen up your bottlenecks

Freeing up beds isn't all that easy. Intake Units, Discharge Lounges and Intake/Discharge Centers, however, can alleviate the common pressure points that slow down patient flow.

Effectively handling your patient throughput can mean added value to your bottom line through increased revenue and greater patient satisfaction.

(Pattie Kloehn is executive vice president at Zimmerman & Associates, and she can be reached at (800) 525-0133. This article is reprinted with permission from Patient Access Monthly).

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Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

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November 2003	September 5, 2003
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Healthcare Financial Management Association First Illinois Chapter

2003-2004 Calendar

Month	Responsible Committee	Format	Date	Location
November	IT Committee	Half day	Thursday, 11/20/03	Maggiano's Little Italy OakBrook, IL
December	Revenue Cycle	Full day	Tuesday, 12/16/03	The Carlisle Lombard, IL
January	Accounting and Reimbursement	Full day	Thursday, 1/15/04	The Carlisle Lombard, IL
February	Medical Group Practice	Full day	Thursday, 2/19/04	Gardner, Carton & Douglas Chicago, IL
March	Managed Care	Full day	Thursday, 3/25/04	The Carlisle Lombard, IL
April	Continuum of Care	Half day	Thursday, 4/15/04	IHA Naperville, IL
May	CFO	Full day	Friday, 5/7/04	TBD
May	Annual Golf Outing	Full day	Friday, 5/28/04	St. Andrews Golf Club

The First Illinois Chapter

The First Illinois Chapter wishes to recognize and thank our sponsors. We are pleased to welcome our newest sponsors, RSM McGladrey and McGladrey & Pullen LLP; and Deloitte. Thank you all for your generous support of the Chapter and its activities.

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