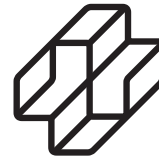


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Process Change Is a Team Effort

By Jennifer Swindle

Including all affected parties in planning a process change can prevent costly mistakes and improve patient service.

“I wish someone had asked me.”

How often those words are spoken by physicians and hospital staff—usually in the wake of a major process change that was implemented without consulting everyone who would be affected, often with disastrous results. Here’s an example.

As a hospital-affiliated group practice installed a new electronic medical record system with all the bells and whistles, EMR training staff demonstrated the coding tool for physicians. The physicians took to it immediately, and soon were relying on the EMR to generate most codes.

But that didn’t last long. Medical record audits by experienced coders quickly turned up dozens of evaluation and management codes and even a few hospital admission diagnosis codes not supported by chart notes. Needless to say, the physicians were furious. They had used the codes the computer had recommended.

Either the coders were wrong or the EMR coding tool was no good, they argued.

Neither was true. The problem was that the trainers knew a lot about the EMR, but not much about coding. They incorrectly gave the physicians the impression that the codes generated by the system should always be used. But when physicians include free text notes, the EMR code generator ignores the information, resulting in incorrect code suggestions. This response not only leads to rejected claims and slowed cash flow, but also exposes providers to potential penalties in case of Medicare and health plan audits. For this and other compliance reasons, EMR-generated codes always should be checked against the record to ensure that they match.

This problem was solved by retraining the physicians on proper use of the coding tool. But it could have—and should have—been avoided in the first place by involving coders in the EMR

implementation and training process. Their expertise was essential to get these major process changes right.

Think Outside the Box

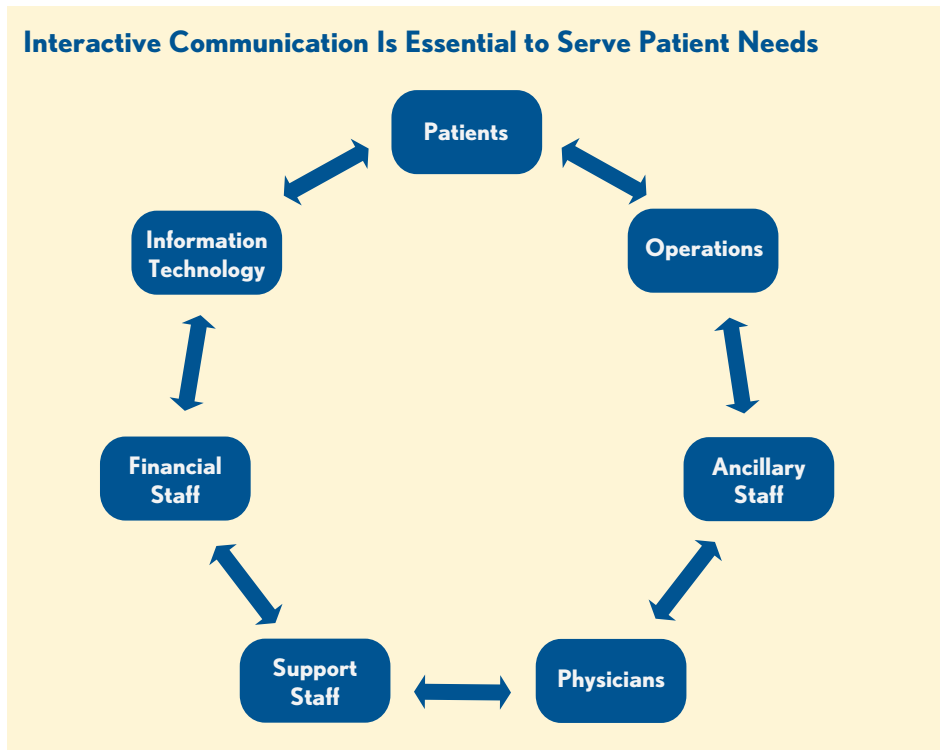
Failure to involve affected parties in process change decisions is a common and often costly provider problem. People often complain that they are not included or asked for input when a hospital or group practice process that directly affects them is changed. Frequently, the change is made by a manager from another department. In many cases, the negative effects of the change are so severe that they require the immediate shutdown and redesign of processes that had just been implemented.

Managers often must make quick decisions for the good of the organization, and it is not always possible to seek input from every affected staff member, much less make them all happy. However, communication is a vital and necessary component of every well-run hospital, health system, and medical group. Quick decisions that appear to save time or money often end up costing even more due to complications that were never considered.

Managers can avoid this problem by thinking “outside the box” when considering a process change. This type of thinking often means considering the impact on other departments. It helps to keep in mind that provider operations are complex and interconnected. The patient encounter goes far beyond the time spent with the physician or in the hospital. It starts with the initial call and does not end until the bill for care or services received is completely resolved—often days or weeks later. During that time, many behind-the-scenes functions that may not appear to have a role in patient care significantly affect both patient care and patient satisfaction, and it’s not always easy to see how they will interrelate.

For example, in another group, senior contracting staff signed a contract with a new healthcare plan with the goal of bringing in more patients. Sounds fine, but the billing department was not in the loop, so the system was not set up to apply the contract discounts. The result was lots of incorrect bills that took lots of time and expense to adjust. Even more damaging, patients were not happy. It took considerable effort to diffuse their frustrations, and some patients probably were lost to the organization.

The challenge is even more complex in hospitals. In many, incomplete or incorrect patient demographic or insurance information is a leading cause of rejected claims. Failure to follow preauthorization, bundling, discounting, and other contractual rules and diagnosis and procedure coding incompatibilities are also high on the list. It takes far more than a claims editor to rectify such errors. It requires coordinating activities of not only revenue cycle and other business departments, but also all clinical departments to avoid making these mistakes in the first place. As insurers and Medicare move toward global payments that



include both hospital and physician services, demands for coordination with multiple inpatient and ambulatory providers will only grow in number and complexity.

Bring the Team Together

To ensure good service for patients, all stakeholders need to be brought together to discuss the potential impact of any significant change before the change is made. For example, in the EMR coding case, the coding department should collaborate with all staff responsible for generating documentation to establish standards and processes for using the system. Both should work with IT staff to ensure that necessary hardware and software support are in place.

In hospitals, contract negotiators and managers should be in constant contact with revenue cycle managers. Among the goals is to get proper patient demographic and preauthorization requirements, and accurate copayment, coinsurance, and deductible information to preregistration and registration personnel. Negotiated bundling and discounting information should be shared with billing staff. Any

unusual intake requirements should be shared with clinical staff to ensure proper documentation of admissions. And billing and collections staff should be in constant contact with intake, clinical, and coding and billing staff to alert them to errors or changes in documentation requirements, or new interpretations of existing rules that provoke claims denials or create audit risk. Bringing emergency department staff into the mix is especially important as ED patients often generate a disproportionate share of uncollectible accounts.

Although this approach sounds like a lot of meetings—something cost-conscious managers would like to avoid—it does not apply to minor day-to-day decisions. Rather, the approach concerns significant changes to a provider’s process or business. In these cases, the time spent in meetings can generate a significant return.

Meetings should be well planned, follow an agenda, and include all the necessary “players.” Putting the right team together makes for a better thought-out initial plan, a more successful implementation,

and a more effective, efficient overall strategy for the organization. Although operational, financial, and support staff work in separate departments, they should communicate and work together as a team. This is not a top-down model, but a circular model. Patients are the crucial factor, for without patients, providers have no business.

So the next time you are making a decision for your department, take a moment to think it through. Consider whether it might affect others outside your area. If it will, include them from the start. When communication takes place up front rather than after a decision has been made (when the potential for negative impact is higher), you are much more likely to get the support you need

for a successful process improvement. Remember, health care is a team endeavor. The most efficient healthcare team is one that works together to score a win for every patient. ☺

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