

ADMIT REDESIGN



**Bunkie General
Hospital**

Personalized Care and Concern

Introduction/Background



- May 2007 New Leadership with emphasis on Strategic Plan that incorporates **Quality**
- February 2008 hospital converted from paper to a fully integrated, electronic system with CPSI
- Strategic Research demonstrated concern over the following issues:
 - **Patient** complaints about the length of time to complete diagnostic work
 - **Radiologist** complaint - BGH had the greatest number of denials for lack of medical necessity out to their 3 hospitals
 - **Local Nursing Home** calling with complaints on problem lab issues
 - **Home Health Agencies** complaints about turnaround times for lab results and also misplacing specimens
 - **BGH coding and billing** staff performing duplicate work
 - **Diagnostic staff** complaining about ABN's and Medical necessity and not wanting to discuss financials with patients

ACTION

- Created a multi disciplinary team with internal and external components
- The team consisted of :

INTERNAL

- Admitting supervisor
- Lab director
- Radiology director
- IT department
- HIM department
- Medicare biller
- Nursing staff
- Administration

EXTERNAL

- Local Nursing Home
- Home Health Agencies (4)

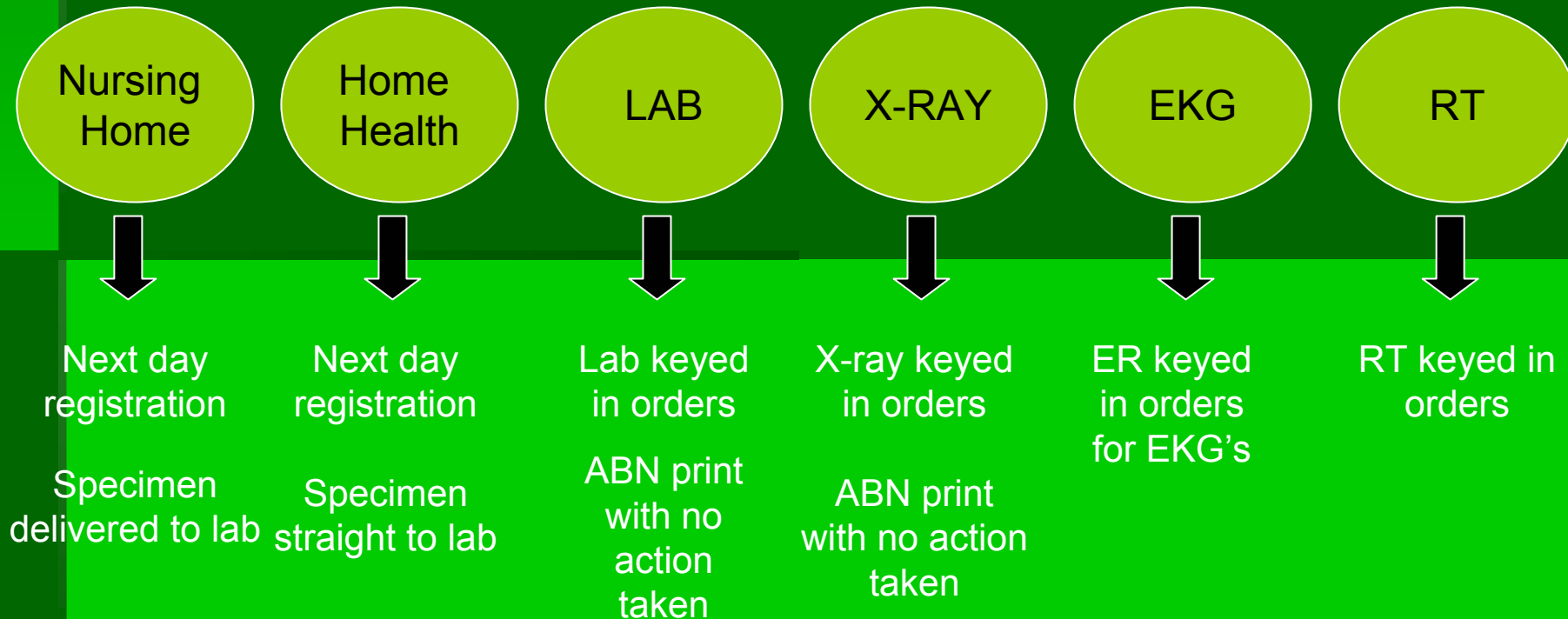
- Designed a new Registration Process
- Created a new requisition form for better efficiency



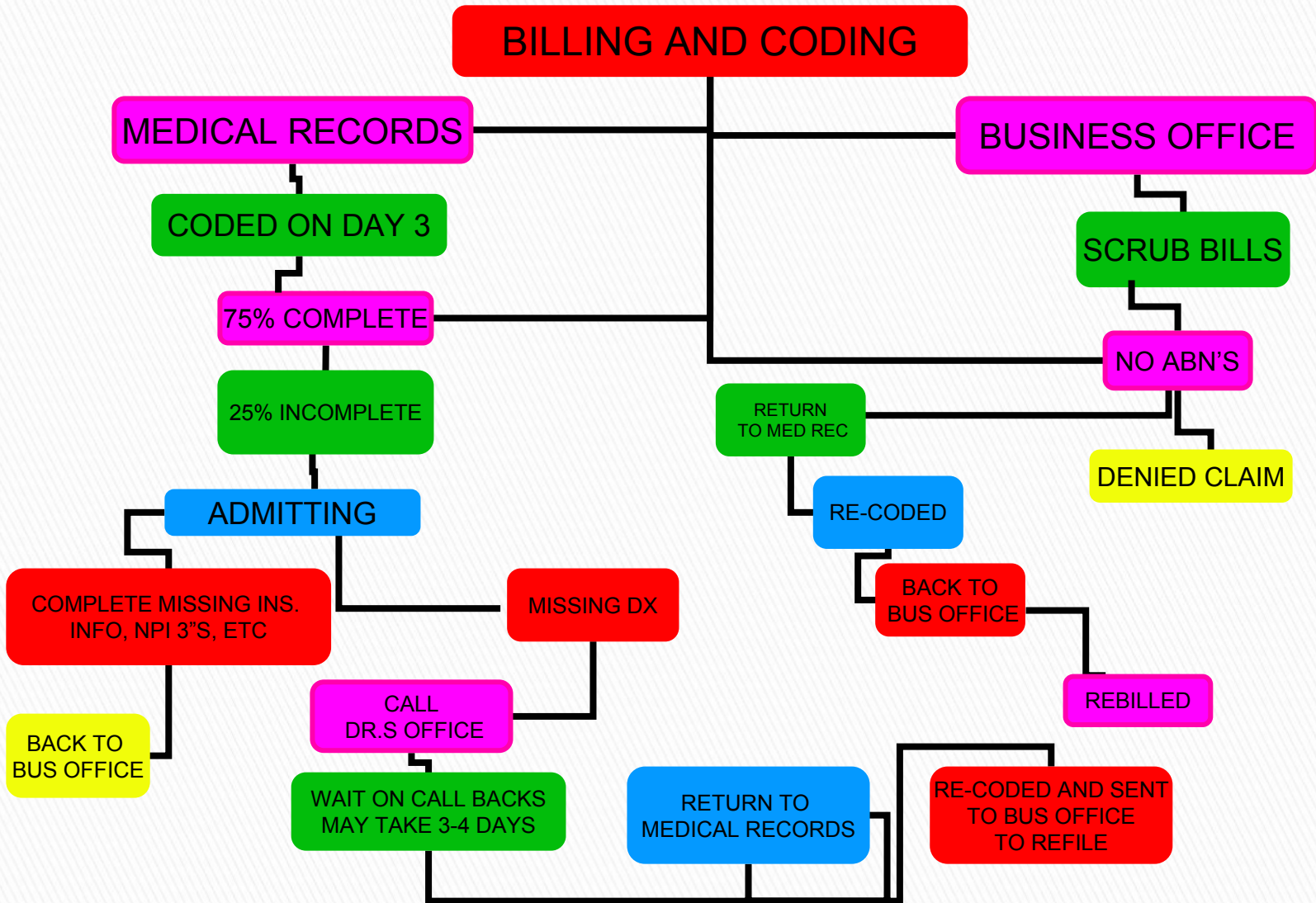
PRE-REDESIGN- REGISTRATION

ADMITTING

DEMOGRAPHICS INFORMATION ONLY



PRE REDESIGN



POST REDESIGN

ADMIT

Complete registration

↓
Does all order entry

↓
Completes ABN if necessary

↓
Follow up with MD office for ABN issues

Ancillary Non-hospital NH & HH

Specimen and orders dropped off and signed in with the admissions clerk

↓
Complete registration

↓
Delivers specimen to proper ancillary dept.

Ancillary depts.

ONLY draw patients or perform tests needed

Coding and billing

Coded

↓
Billed – usually a one day turn around time

↓
On occasion, will be returned for not meeting medical necessity



- Average 50 claims per day
- 25 % of claims not coded
- 15% of not coded – did not meet medical necessity
- Estimated 487 claims annually with no ABN
- Average charge/claim = \$143
- Estimated Annual Impact:
 - \$69,641 write off
 - One day billing cycle versus 7 – 10 days

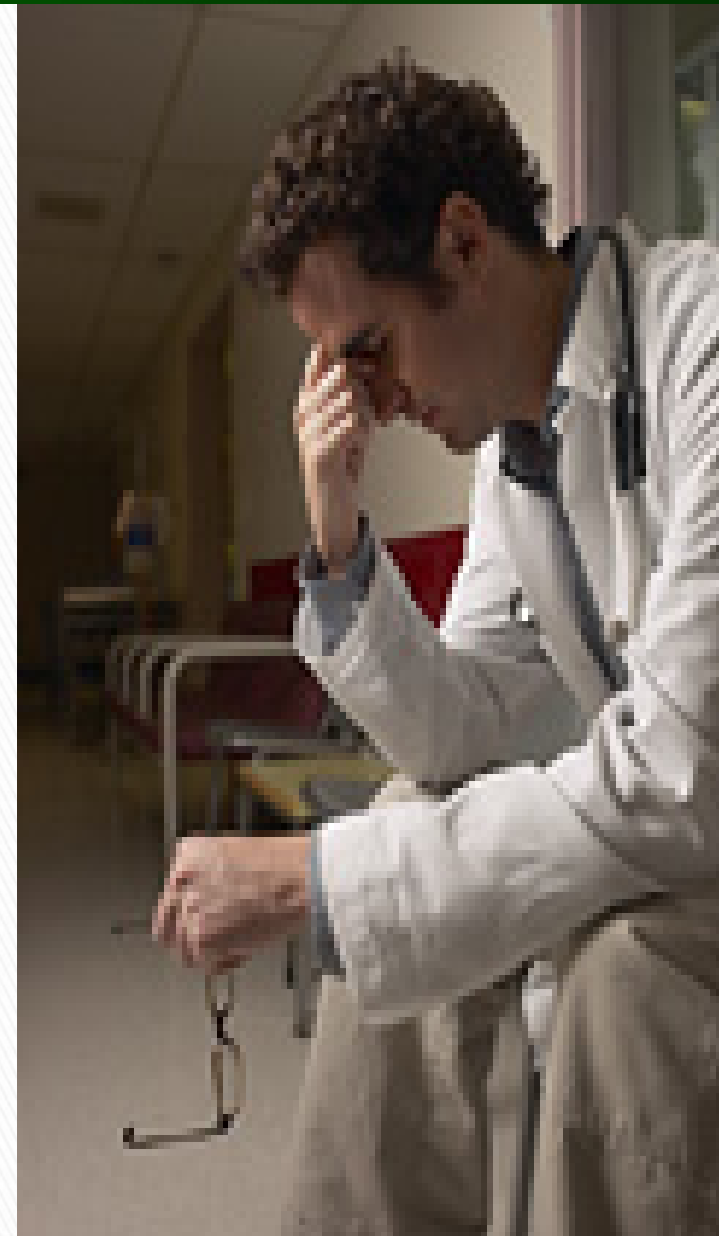
OTHER IMPACT

- Increased patient Satisfaction
- Increased Customer Satisfaction (internal and external)





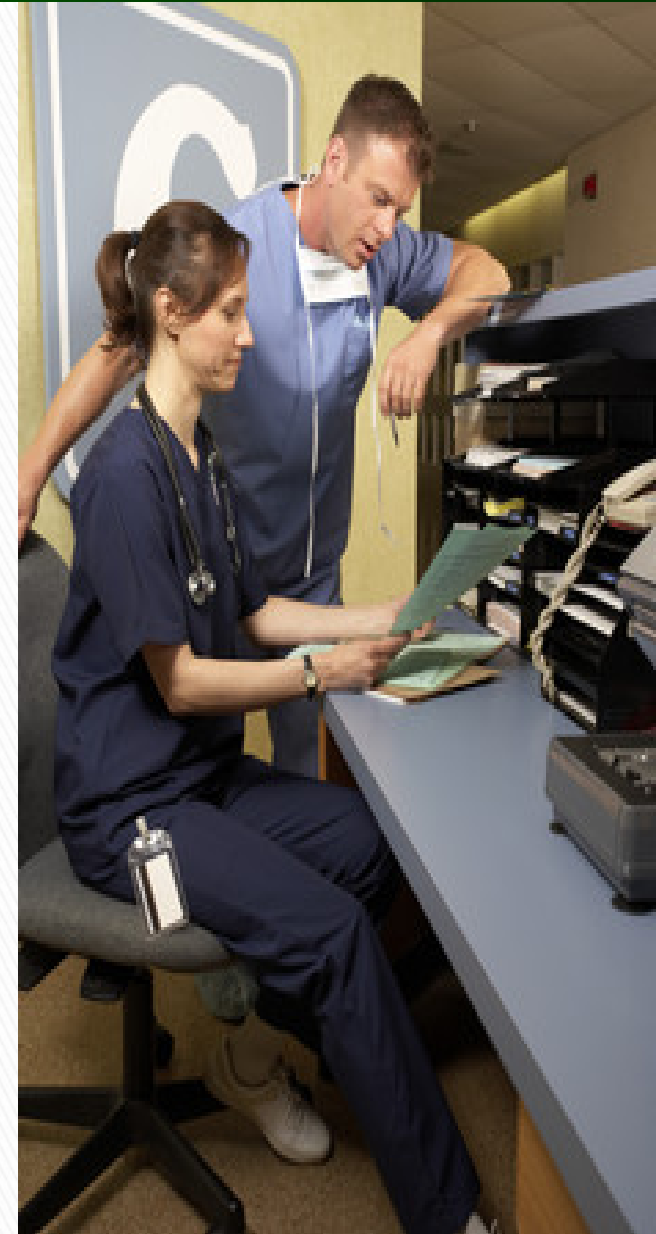
The cost of quality in a typical healthcare organization is between 20 and 35% of its earned revenues. For organizations with weak quality programs it is as much as 45% and climbing every day.





Cost of Poor Quality

- Rework (getting it right on the second try)
- Diagnostics (cost of discovering what went wrong)
- Dealing with patient complaints
- Re-inspections
- Write-offs
- Penalties
- Liability costs
- Non-payment for never events
- Non-payment under pay-for performance
- Loss of reputation and goodwill
- Soft quality
- Loss of patient volume
- Staff turn-over
- Cost of defensive medicine





Cost of Quality Program

- Quality program overhead (staff, equipment, etc.)
- Quality control activities
- Quality auditing
- Preventive maintenance
- Diagnostics (cost of discovering what went wrong)
- Inspection preparation and rework
- Re-inspections
- Practice of defensive medicine
- Accreditation readiness
- Managing your change management engine (cost of implementing improvement plans and managing them to hold the new performance)





Do It Once and Do It Right!





A healthy quality program is about:

- ❑ A health care provider's relationship with its community and patients
- ❑ Making sure our health care systems are designed and operated to be everything they can be for the people who depend on them
- ❑ Reaching for greatness and never settling for simply being good
- ❑ Restoring public trust in health care
- ❑ Holding that trust once we have it

THANK YOU

QUESTIONS

AND

ANSWERS