Draft Report
8th Annual I/T/U Business Office/HIM/CHS PartnerShip Training Conference
"You Are the Essential Piece"

April 18-20th, 2006, Reno, NV

Background

The purpose of the "Partnership" training conference for the past 8 years is to provide business process training or revenue cycle training to Service Unit operations and Area staff who work in the Business Office, CHS program and HIM Programs/Departments. In 2006, during the 3 day session, over 100 sessions were provided focusing on building knowledge, skills and abilities of staff who work on a day to day basis in these program areas. The sessions were selected by the partnership planning committee composed of IHS and Tribal staff from BO, HIM and CHS. By building the various business process skills, additional revenue will be gained through increase collections and/or efficient payments resulting in resources that can be used for maintaining and improving access to clinical/preventive and CHS health care services. The bottom line (ROI, return on investment), is that staff who attend the partnership ***training*** conference will increase their knowledge, skills and abilities in the business process which leads to "performance improvement" in their jobs when they return to the Service Unit.

Through the NBOC and 8 partnership training conferences over 3000 IHS and Tribal staff have attended these meetings. Below are the themes of the conferences:

- "Preparing for Challenges in Third Party Claims Processing, 1999"
- "Building the Foundation, 2000"
- "Together Everybody Achieves More,2001"
- "Strengthening our Partnership for Healthier Indian Communities, 2002
- "Partners for Compliance, 2003"
- "Bringing the Partners Together, 2004"
- "Planning Solutions to Improve Business Process, 2005"
- "You are the Essential Piece" 2006

In addition, through the NBOC there have been 5 training conferences targeted at CEOs and BOMS (Business Office Managers). The first 4 focused on building the basics per below. The second one was held in 2005 in Tucson focusing on business process, revenue management and PAMs preparation.

- "101 Management Meeting/Training "Raising Health Status by Effective and Efficient Third Party Revenue Management, 2002 and 03" (4 sessions)
- "CEO/BOM training in 2005"

HOW CAN I USE THIS REPORT?

The report should be reviewed and discussed by your BO, HIM and CHS staff in your Service Unit to verify the findings and reports by the various programs for applicability to their Department, Hospital or Clinic. If there are any ideas in this document please use them to improve your business process. If there are any additional ideas or comments on this information, please send them to Elmer Brewster at IHS HQs or your Area BOC, Area HIM Consultant or Area CHSO. The draft report is intended to provide you with information that you may find useful in running your programs.

Program Area Breakout Sessions—Afternoon of the First Day of Partnership For all Disciplines

The objective of the Program breakout sessions were 1) To provide up-to-date information on IHS wide projects/activities that will improve the Business Process, 2) To provide an opportunity for staff to ask any questions specific to their program area, and 3) To "pick your brains" via the planning session on how we can do our jobs better in the Program Areas, BO, HIM, CHS.

Business Office Breakout Session

AGENDA

1-230PM KEY INFORMATION REPORTS FOR BO STAFF

DBOE Performance Standards, FY 2006	Elmer Brewster, Director, Division of Business Office Enhancements (DBOE)
Third Party Accounts Management and Internal control Control Policy Update	John Rael, Program Analyst, (DBOE)
BO web site	Kris Kirk, Program Analyst, (DBOE)
Business Process Update (all sites)	Kris Kirk, Program Analyst, (DBOE)
Revenue Operations Manual (ROM) Update	Sharon Sorrel, Business Office Manager, Gallup Indian Medical Center
ORAP/OIT Projects	Sandra Lahi, Senior Program Analyst (DBOE)
National Business Office Committee workplan/workgroups	Roland Todacheenie, Navajo Area Business Office Coordinator and Leah Tom, Portland Area Business Office Coordinator
Office of Inspector General Update (OIG)	Cynthia Larsen, Billings Area Business Office Coordinator

Strategic Planning Session, 3-430pm DBOE, BOCs & YOU

The information generated from this planning session will be posted on the BO web site. On Thursday afternoon, all 3 Partnership programs will report back in general session. The information will be organized into 1 report for Leadership and used to plan additional activities in 2006 and 2007. Your insight and feedback is appreciated!

Breakout groups will be set up to address the following key questions? BOCs are assigned to facilitate.

*1. **Best Practices** in the Business Office in the following Areas.*

1. Patient Registration — Sandra Lahi
2. Patient Benefits — Mary Beaver, Adam Archuleta
3. Billing — Cynthia Larsen, Kathy Bristlin
4. Accts. Receivable — Toni Johnson, Kurt Priessman
5. Bus Office Managers — Sharon Sorrell, Adrian Lujan, Kris Kirk
6. CEOs — Elmer Brewster, Roland Todacheenie, John Rael

Chief Executive Officers

Question #1

What does your Business Office Manager do that is effective in third party revenue management?

- Communication with patient registration, Billers, Providers, etc. – Daily and monthly reconciliation processes.
- Developing useful trend analysis addressing BP.
- Following up on the Business Office Process Checklist weekly

Question #2

In managing your AR aging balances over 90 days, what is effective or successful?

- Follow-Up on claims over 30 days to keep the aging accounts down
- Keeping Manageable aging percentages % by Working Claims.
- Streamlining the insurance/third party verification system on check in.
- Work GP Net daily
- Adequate staff to keep up on requirements
- Using Transworld to help with follow up.

Question #3

In order to implement the new Third Party Internal Control Policy, what would you recommend to other CEO's?

- Low Staffing Levels – identify other manpower solutions

- Education of Tribal Health Boards/Councils on internal controls policy and the importance in using it to protect and increase our third party revenue
- R.O.I., Return on Investment
- Streamline Business and Clinical process to align our ability to meet IC guidelines.
- CEO's need to learn, know and interact with entire process.
- Knowing indicators on staffing, productivity, weekly and monthly reports.

Question #4

What have you found that is successful in optimizing the collection of third party revenue?

- Online verification systems and checking these the day before to identify patients that may need to be sent to patient benefits coordinator.
- E-Claims processing
- Patient update on every visit all fields
- Everyone's is in the ballpark have a game plan, "revenue is lifeblood"
- Decentralize patient registration process when allowable
- Process in place to I.D. patients that may have opportunity for Alternate resources
- Realistic performance standards
- Educate and train all appropriate staff
- Assess Return on Investment ie., FTE vs Outsourcing

Question #5

Are there any successful ways to make sure CEO's or Service Unit Leadership make decisions that will improve Business Office Operations?

- Weekly meeting with your (BOM)Business Office Managers to keep BO issues on the forefront
- Sell Business Office process to the Provider
- IT involvement in the process
- Education and Training on BP
- Timely meetings
- Be forward thinking and track BP agenda items
- Focus on sub-pop ie., kids, pregnant women, disabilities for alt resource identification

Question #6

Any other CEO Best Practices you would like to share with the group?

- Education of patients on the value of alternate resources and how it can help them and the Community
- M.B.W.A. – Management by Walking Around--Communication

- Viking System and other COTS systems utilizing cost benefits analysis before we scrap them and see if it would be worth investing time to interface with RPMS if it provides a good service or what is it going to cost us if we discontinue the use.
- Utilizing a Balanced Scorecard or Data Dashboard---track performance
- Sharing of reports at Area, HQ and service unit level (i.e. Exec Staff, providers, medical staff, key players in the revenue cycle.)
- Use Pt. Benefits model in 638 so tribes will buy-in to process

Questions #7
Please list your top 5 problems in your business process area?

- I.T. – lack of adequate staffing at service unit level, lack of response by Area and National OIT
- Problems relating to Certified Coders
    - Training standards
    - Retention standards
    - P.D. standards
- Physician Buy-In, i.e. doing own coding if adequate coding staffing is not available.
- Staffing – lack of positions, quality panels, space for staff, not enough staff
- Painfully slow H.R.
- Lack of Benchmarks to compare facilities

Question #8
Please identify your top training needs in your program area – what will improve your job performance?

- Benchmarking – training on how to identify and benchmark with like facilities
- CEO understanding of the Business Office process ie., understanding the numbers, CEO cross training on BP key steps.
- Training similar to the one Sandra Winfrey provided to PIMC, on productivity and reports
- Training on HQ mandates

Question #9
What are your top 5 recommendations for generating third party revenue---look into your *crystal ball*?

- Online verification interface with RPMS 270/271
- Tracking Medicare & Medicaid reform
- Negotiate good rates with Network providers
- Alternate Resources Manual

Business Office – Billing Third Party Payers

Please list top 5 problems in your billing process area

- No policies and procedures
- RPMS/IT issues
- Process changes with EHR & Internal Control Policy
- Patient Registration not gathering, verifying and/or entering third party information
- Staffing
    - Lack of staffing
    - High turnover
    - Retention issues
    - Training issues

Please identify your top training needs in your area – what will improve your job performance?

- Certified Coding
    - On-going ICD9, CPT/HCPCS training
- Documentation training for providers
- Electronic Health Record training
- Cross Training w/Patient Registration so they know what affects the billing
    - Patient Registration
- Sequencing w/Patient Registration so everyone knows how to coordinate benefits
    - Coordination of Benefits

What are your top 5 recommendations for generating third party revenue – look into your crystal *ball?*

- Smooth processes
- All electronic billing
- More IT support for the Tribes
- More qualified staff
- RPMS Site training for IT staff to assist w/troubleshooting

What has been positive or successful?

- EHR "team approach"
    - Increased revenue
    - "easier" billing
    - Clinical Applications Coordinator support
    - Accountability (providers, coders, etc)
- Certified Coders
    - Less errors
    - "easier" billing
- Certified Biller
    - Identifies Medical Necessity
- Tapped New Revenue

    - Ambulance
- Patient Registration Enhancements
    - On line Eligibility

Patient Registration Break Out Questions

1. What training techniques have you implemented that has been successful in cross training NEW patient registration staff?

- Customer service. Develop a comfort level with patients
- Pt Reg RPMS Page 9. How to capture information on patients.
- Interviewing techniques
- How to complete 3rd party eligibility pages
- Educate the staff on RPMS software updates as well as the outside clinic staff
- Developing a training manual
- Communicating the importance of each policy and procedure for the facility
- Developing power point presentations to in-service staff
- Understanding the importance of insurances as:
    - Sequencing in Insurances in RPMS
    - Auto liability information
    - Developing flagging procedures to identify patients for referrals to Benefits Coordinators

2. What training tools have you used to train staff on the Coordination of Benefits and Sequencing in the RPMS Patient Registration application?

- Identifying and printing from RPMS the top 10 Insurers and developing steps of capturing information for each.

3. What processes have you implemented that have been successful in reducing errors/warnings and keeping the RPMS error/warning report at a manageable level?

- When printing errors from RPMS, only select the ones that apply to your facility
- When dealing with MSPQs, mail documents to the next of kins for signatures.
- Change errors to warnings if the error does not apply to your facility.

4. In cross training and demonstrating "Excellent Customer Service" to our patients, what are some successful customer service techniques or tips that you use?

- Demonstrate by having staff do reverse role playing
- Greet with a smile and always saying thank you
- Express empathy with the patients as they are at the facility for health care
- Taking ownership of the area that is being worked by providing guidance, directions, wheel chairs, etc.
- When training staff, emphasize the fact that the patients are the customers

5. Do you have any successful techniques that are successful when verifying third party eligibility information for Page 4 of Patient Registration?

- On line eligibility if the Payer offers it via websites, etc.
- Identifying one person in Patient Registration to update all of the eligibility
- Using Cheat sheets to list specific information that RPMS needs
- Using a Private Insurance worksheet
- Verifying patients eligibility on every visit
- Enter in termination dates
- Private Insurance verification entered on page 8 that information was verified along with date verified, initial of person who verified and who they spoke to, etc.
- Copy of cards and worksheets submitted to billing staff

6. What success stories can you share with interviewing and entering Medicare Part D payers into Patient Registration RPMS?

- Have the benefits coordinator review patient data to document eligible patients
- Cross train Patient Registration staff to begin process also doing Medicare Part D applications
- Print an RPMS dual eligible listing of patients with both Medicare and Medicaid and contact these patients to identify payer
- Work with the Pharmacy application coordinator
- Calling CMS to obtain eligibility information
- Checking patient medications to see if the drug is on the Payer listing

7. What is the best way to capture third party information after hours or in the Emergency Room?

- Use mini-update forms for other providers to have the patients complete after hours.
- Have patient registration staff provide 24 hour coverage
- Providing coverage in all the clinics by decentralizing
- Ensuring Benefits Coordination applications are available after hours

- Rotating staff to the ER by shifts
- Calling other Service Units if you have patients with incomplete information
- Having non bens sign forms for payment responsibilities and billing them for services
- Implementing credit card, money orders and receipt of cash procedures

8. Are there any other patient registration best practices/tips you would like to share with the group?

- Interviewing patients at every encounter
- Sequencing every encounter
- Correcting errors immediately and on the spot during interview
- Provide feedback on every employee both good and bad reviews.
- Use management reports to demonstrate competency levels and workload

9. Please list top 5 problem areas in your business process area?

- Patient Registration is not the initial point of contact for patients checking into the facility
- Information is not being documented in RPMS that the patient information was updated which hinders communication efforts between staff
- Providers need to be educated on the importance of Patient Registration
- Quovadx response time is slow and the downtime is too often.
- Problems with data entry as names that create errors on the 837 claims
- Lack of cross training to Appointment Clerks who are not scanning for existing patient names but entering in duplicate patients in RPMS

10. Please identify your top training needs in your program area—what will improve your job performance?

- Training on RPMS and the new features
- Training on Payer billing rules

11. What are your top 5 recommendations in for generating third party revenue---look into your *crystal ball?*

- Support from the facility management staff on the issues identified on number 9

Accounts Receivable Break Out

1. **What does your Business Office Manager do that is effective in third party revenue management and that helps you do your job?**

    - Open communication of progress/backlogs, etc.

- Working manager knowledgeable of all facets of AR and can help when needed

2. **In managing your AR aging balances over 90 days, what is effective or successful?**

    - Manage A/R Payers at earliest opportunity – reduces 60-90-120 day A/R
    - Post zero pays
    - POS clean up can help

3. **What successful training techniques do you use to teach new employees on how to read explanations of benefits or remittance advices for posting payments and adjustments?**

    - Obtain help/training from payer
    - Policies and procedures or guides which provide step-by-step guidance

4. **What processes have you found to be successful in working secondary or tertiary bills?**

    - Facilitate cooperative processes by identifying secondary/tertiary payers to PR from knowledge of plan and/or CHS (FI)

5. **What processes work to minimize claim denials?**

    - Identification of errors to PR, coding, data entry or billing
    - Emphasis on front end processes
        - Copies of cards – suggest a card scanner
        - Verification only staff
        - Designate person to fix and re-bill

6. **Are there successful ways to work together with CEOs/or SU leadership to make decisions that will improve Business Office Operations?**

    - Business process coordinator to work with CEO
    - Revenue Process Committee
    - Educate, educate, educate

7. **Any other AR best practices you would like to share with the group?**

    - Automated posting of 835s
    - Contracts with payers

8. **Please list your top 5 problems in your business process area?**

    - Verification at the start

- Backlogs
- Staffing – lack of experience
- Errors in RPMS patches and new releases
- Importance of AR

9. Please identify your top training needs in your program area—<u>what will improve your job performance?</u>

- Training from payer on specific problems
- Training across revenue spectrum

10. What are your top 5 recommendations for generating third party revenue--look into your *crystal ball*?

- Contracting with more payers
- Collecting co-pays/deductibles from non-bens
- More efficient billing through AR identifying problems
- New programs (MMA)
- Stronger Coordination of Benefits Program
- Better position descriptions and more staff
- More supportive/responsive information system

Business Office Managers Breakout

1. **Problems, Barriers, Issues**
    a. 4-day coding – tracking PCC forms and Providers
        i. Ongoing issue
        ii. No provider accountability
        iii. Possible solution: Provider education by the Business Office
    b. Staffing
    c. Space
    d. Training for all staff
    e. Provider Documentation
    f. Area Office support
    g. Provider credentialing
    h. Staff Retention
        i. Raises for coding/billing
    i. IT Support
    j. Staff productivity
    k. BOM Training
    l.
2. **Goals**
    a. Staff certification – coders
    b. Upgrades – pay increases
3. **What does your management do that is effective?**
    a. CEO has prior BO knowledge

b. CEO is involved in BO activity
c. CEO reviews reports
d. CEO empowers BO to meet their goals
e. CEO sets revenue goals
f. Invites Clinical Director/AO's to educate other CD/AO's
g. CEO has quarterly meetings

4. Best practices used to manage?

a. Verbal praise
b. Empowerment
c. Awards
d. Celebrate birthdays, holidays, collection goals
e. More training on new processes
f. Cross-training staff
g. Provide collection updates
h. Monthly meetings
i. Issues addressed immediately
j. Teamwork-other departments
k. Peer reviews
l. Involving staff in process
m. Good problem solving
n. Communication
o. One-on-one training

5. Any successful ways to make sure leadership make positive decisions?

a. Provide reports prior to making decisions
    i. Monthly
b. Adequate time for training for CEO
c. Ensure understanding of reports
d. Business Office staff needs – equipment, etc.
e. Provider workload data
f. Establish leadership due to turnover

6. As Business Office Managers, what have you done to produce results?

a. Review and changed processes
b. Provides guidance/feedback that affects collections
c. Motivate=>promote teamwork
d. Awards
e. Upgrade positions – career ladder
f. Written workflow
g. Set goals (individual)
h. Developed and enforced policy and procedures
i. Encourage to "think outside the box"
j. Provide –interpret new guidelines
k. Staff empowerment
l. System-wide updates

7. Medicare Part A top ten billing errors

a. HCPCS code required by line item
    i. McMannis

        ii. GP Net
    b. HCPCS code invalid
        i. Patch not loaded in time
        ii. Identify source of problem
    c. Admission source missing
    d. Principle diagnosis code V04.81 and/or V03.82 with A6 condition code
        i. Immunization billing
    e. Discharge missing
    f. Provider not eligible after term date
    g. HIC Invalid
    h. Condition code 21 present but no non-covered charges
    i. UPIN missing
    j. Total charges not matching on UB92
8. **Medicare Part B top ten billing errors**
    a. Place of Service codes
    b. Provider eligibility
        i. Need changes in RPMS to notify user
    c. CLIA #
    d. Part A services
    e. Duplicates
    f. Beneficiary eligibility
    g. Medical necessity not met
    h. Bundled services
    i. Professional component modifier invalid or missing
    j. Screening services

Patient Benefits Coordination

PBC needs: Extra resources, i.e., cell phones, fax machines, marketing budget to purchase outreach items, government car, additional office space for privacy, HIPAA concerns.

Marketing initiatives: additional time for radio, television, newsletters, and health fairs, etc.

Incentives for PBC's: recognition for PBC activities, awards, PD updates, and possibly bonuses (QSI), etc.

Management Support: Clarification of assigned PBC duties, additional FTE's, how much CHS dollars saved and/or third party revenue generated.

Training: additional PBC training, both internally from other Bus Office areas, to external training by State Medicaid/SCHIP programs, Social Security, commercial insurance plans, etc.

Productivity: Access to more RPMS packages, CHS, RCIS, Third Party, A/R, etc. Start utilizing PBC page 5 and PBC reports options. Establishing benchmarks.

Cross-Training: All BO/HIM need to be involved in PBC process, as well as PBC's understanding the revenue flow process.

IT/Computer Support: Having e-file capability for alternate resource applications, electronic signature for presumptive applications, etc.

Communication: All departments need to have better communication in order to maximize alternate resource enrollments.

Health Information Management (HIM) Program Break-out

1) More education needed re: HIM issues in EHR environment and just plain training on how to use EHR. Very obvious, lots of people just getting started with implementing EHR and they really do not know where to start.
2) Many questions on Coding queue and what reports to run in verifying/checking which visits still are not complete.
3) How to correct errors in EHR, like wrong patient, wrong chart and who is responsible, HIM or CAC.
4) How to analyze in the EHR for completeness for both paper and EHR – how to manage the workload for both. Split staff up to work both EHR and paper, or assign providers to each Coder/DE/Analyzer person and they keep track of both paper and EHR visits. Best practice.
5) HIM Directors stepping up to the plate and taking an active role in EHR implementation and working closely with their CAC
6) Turning on and off mandatory fields
7) Turning on and off Notifications
8) Who should be coding in EHR, providers or coders.
9) Recommended that coding be done by coders and not providers as the VA in Salt Lake has done.
10) Inpatient EHR – Fort Defiance explained to us how it works. Need more on this and what to expect, maybe Ft. Defiance can give us a one-page document explaining what were in for so to speak.
11) Auditing in EHR? Need a P&P developed.

Release of Information (ROI) Issues

1. More training needed on ROI Package
2. Some facilities are still not documenting their ROI on IHS approved software/package.
3. Training needed on FOIA/PA/ HIPAA privacy Rule.

4. How to delete errors in ROI package – Klamath Service Unit will write how to delete errors in ROI and send to the group through one of the HIM Consultants.
5. ABQ Area HIM Consultant will write on how to create certain reports on ROI package.

ICD-10/CPT-10 Implementation

1. Is HQE going to take the lead?
2. Role HIM at Service Unit/ Area and Hqrs in implementing new coding system.
3. Role of BO
4. Coding certification
5. Will current coders have to retake their certifications?
6. Upgrade of coding positions to higher level.
7. Bring back coding functions to facilities instead of contracting in Aberdeen area.

HIM Funding.

1. HIM is not as well funded as BO.
2. Request HQE fund HIM for training and conference attendance as BOCs
3. Need full time HIM consultant at HQE
4. Part time consulting responsibilities does not fully serve the interest of HIM.
5. Raise grades of HIM Directors at facilities equally across all IHS areas.

Accreditation Issues.

1. CMS Surveys.
2. Unannounced Surveys and how to prepare for it.
3. Some questions asked by surveyors were shared.
4. Actual surveyors' questions will be shared with Him Consultants.

Provider Education

1. Provider education – the missing link to accurate coding and higher reimbursements.
2. Provide on-going provider education at all facilities.
3. Provider education – not a one-time thing.
4. Train at least two staff in each facility to provide quick provider documentation to locums.

Contract Health Service Breakout

CHS Round Table Discussion; Round Table Q & A Session; and the Evaluation

Tuesday: April 18, 2006: 1:00 P.M – 4:30 P.M. **ROOM: N 1-4**

CHS Round Table Session – Discussion of conference presentations and discussion on several topics. Topics to include but is not limited to: CHS Overview, Initiatives, and New Regulations and Legislations: Best Practices, National CHS Workplan, Area Director's CHS Workgroup, Budget, CHEF Update, RPMS (Enhancement to CHEF cases - auto vs. manual), Contracting Issues (RCIS & Entering Data, DCIS, UFMS, PRISM), Medicare Modernization Act & CHS Connection (Medicare Part D, Premiums, Medicare Like Rates, Across State Borders). The overview of the conference and CHS issues needing to be brought forward. The breakout groups activities within the roundtable session. Four groups met for 2 hours on the following CHS issues: Strategic planning & best practices; Issues/Concerns; Customer Service within CHS; and CHS Information Needs. (Summary of breakout on separate attachment)

The Tuesday afternoon session had just over CHS 160 attendees in the room. Conference registration just over 608 with around 30 on site registration.

Thursday: April 20, 2006: 1:00 P.M – 2:30 P.M.

Round Table Close Out Session: The CHS roundtable is intended as an overview of the CHS Program and current activities that impact the workload and services to AI/patients. Information from the evaluation will used plan future CHS information/training opportunities that will take place next planned conference.

Evaluation Responses:

Was this training useful in helping you to better understand CHS program? Why?

YES: 44 NO: 3 0 Response: 27

Comments: why

- Nice to know why we do the things we do – not just doing the work
- Really like the break out sessions
- Very Helpful
- Areas to focus; please don't forget long term concerns about risky behaviors and limited CHS resources. Create National (CHS providers contracts) Team with Tribal representations to negotiate contracts
- If helps when you can discuss how others deal with CHS situations
- Helped to participate in the sharing of process and procedures
- New to CHS (1 yr); so very informational
- No – an overview for them. (nothing stated to what they wanted at the conference)
- Other Area shared helpful ideas on how we operate within our CHS
- Prioritizing the many elements of CHS although most are high

- As a CHS specialist, I have a good understanding of the CHS program. However, it has been a learning experience which is always a good thing
- Helps to determine needs
- Helps me understand more about contract health
- My understanding of CHS is now at a higher level than when I came
- Thanks for sponsoring the conference
- The training is great as well - as the networking
- Identification of similar problems – open discussion
- Need to break the roundtable down into more specific details and a better chance to learn from other tribes.
- Need more time to Q & A what each group worked on. You learn much from the individual breakouts, but can miss out on some shared information from others
- Some sessions; undecided information, vague, no clear answers
- Able to network with other Tribes and see how they work and what we can share with each other
- Good to be among Tribes to know they have the same issues; would like more Q & A and problem solving rather than presentations from speakers

1. Do you understand the roles and responsibilities of each level of the CHS program from Headquarters to Area, and Service Unit, or CHS Tribal program?

YES: 50 NO: 9 0 Response: 27

Comments:
- Level of understanding to at SU level
- Funding Formula processing

2. Do you feel that your questions were answered with the correct information to help you with your position?

YES: 53 NO: 3 0 Response: 27

Comments:
- Has the descendent eligibility policy been changed throughout IHS? Phoenix Area and Portland Areas stated that descendents of enrolled beneficiaries are not eligible for CHS off the reservation, although they are residents of the CHSDA. Is this an Area by Area initiative or IHS (Federal) via Tribal facility?
- Acquisition process – CHS should be a specific Acquisition Management group in each Area - the Bemidji Area's contracts are processed through Aberdeen Area Office, our request for contracts are not processed in timely manner.
- Can Headquarters hold the responsibility at their level – CHS contracts only

- More specialized sessions needed
- Most sessions informational to needs
- Some questions re: issues legal or understanding implementation of CRF @ tribal clinics. No point of contacts.

3. Do you feel that your program, tribe, service unit or other programs will benefit from this conferences planned as a joint effort?

YES: 59 NO: 2 0 Response: 27

Comments:

- Our CHS program doesn't currently use the RPMS – we need to do that.
- It helps each Area (Billings), CHS, etc. sometimes this may be confusing to staff

4. What barriers, if any, do you think exists for you, your CHS program to improve the CHS business process and improve customer service?

Comments:

- Each service unit should have their own Work Plan presenter due to doing the same processing
- More rooms for break outs; CHS only conf/training
- Funding; lack of training
- The difference between Area, Tribal & Fed.
- Funding is not at 100%
- Lack of better Funding. Lack of Support from our Administration @ SU level & Area CHS
- I think that we are doing well at this time - Educating School Staff of CHS requirements.
- Learn how other SU Do & help improve our program.
- Standard eligibility factor than just communicating that it's at your discretion (Area Level or Tribal). Makes CHS program more confusing.
- Organization, CHS work flow from SU to FI
- Lack of staff; lack of training & travel resources to meet staff needs. It's April - and we're broke!
- Staff education willingness and unwilling to see patient needs as primary.
- Not enough Money.
- Contracts with Medical Facilities/Providers. Training the Public on IHS CHS regulations.
- Implement RICS Referral at Service Unit CHS Eligibility website
- Medical priority and education
- For the whole Clinic facility to assist with Education from Patient Reg. - all other depts. thru CHS. Not just CHS to have SU input as we are on the front line - or a section on SU level operations.
- Timely renewals/amendments contracts of Medical Services - this is an Area concern.

- Registration is the barrier or rather does create stumbling block to CHS when IHS/Geographic/Demographic is not correct.
- Difference between I/T/U.
- Need better communication, annual CHS meetings/trainings at Area level annually
- Barriers not enough funds to provide all services needed.
- Basic Computer skills on the Clinic side
- Funding issues for training access to CHS issues via internet.
- Customer Services.
- More Tribal experts needed
- Teaching our providers exactly what their role is with IHS & CHS specifically
- Training
- All listed/discussed in our session.
- Shortage of CHS Staff.
- Net working.
- Prompt payment.
- Our programs have used IHS Manual only as a reference & have adopted a short manual only for our Clinics & have taken only the regulations. So this is a conflict in our offices.
- CHS Program IHS, Tribe Urban Program, Supporting group.
- Doing too many other jobs at the same time; were short-staffed.
- Communication between CHS, Clinic providers, and outside providers.
- Lack of patient training
- Being able to get into RPMS System to do hands on work, reports. CHEF more in detail tribal breakout session, not with federal, we are different.
- Patient education getting patient registration to realize how important accuracy and complete information is needed.
- In my program, I have limited pt. contact, except for when they are in collections!
- Educating the patient and the IHS providers as well as contracted vendors/providers.
- Problems computer system, patches make work harder than should be.
- The CHS Program needs to provide literature to CHS Eligible patients so they can understand rights - non rights.

5. List any topics or questions you would like to see addressed at future meetings, trainings, workshops, and other CHS program activities.

Comments:

- RCIS Basic Training, CHS Website, Basic CHS training; Eligibility, Priorities, Negotiating, etc.
- Longer training sessions, more reconciliation, customer service, appeals processing
- 1-2 days designated to one topic only; hands on complete trainings needed.
- Need more time - time limit is not good.
- Better organization preparation of topics & each room be set up for presenters

- Need to let SU Staff be aware of this conference. We did not learn of this conference from our Area Office, but from another Area SU Staff. Funding distribution & CHEF.
- CHEF
- More money and training, have suggested training from this year conference to next year.
- CHEF Training, Area CHSO's attend to give input on their Area's!
- Release of Information.
- Need newer/updated information rather than shaving information that has already been communicated via email. CHEF, FMCRA, Budget (Status of Funds) for CHS.
- Referral limit, denial, deferred, flow of MPO (SU to Area to FI to Core-WEBFRS need Flow Chart). Education materials samples, CHS managing stress difficult patients. National CHS brochure National CHSDA maps and Customer Services.
- Component for CEO's and their challenges and expectations. Managed Care functions (and need for) How do create position with no resources funds. Separate Tribal & Federal training (in some cases) but keep door open. Need tribal breakout; needs to expectations are different.
- Customer Service Training. CHEF details information on requesting for assistance.
- Best practices segment. Business process model program/center of excellence.
- Implement RQM Agreements with Medical providers.
- Correspondence manual improved negotiator process - timeliness of process dealing with difficult people.
- Start the breakout on Monday through Friday. So we can attend more session.
- Create a disk which can be taken with us after the meeting.
- Training, workshops and other program activities.
- 3 days of breakout rather than 1 1/2 - would like to have attended more sessions. Status of Funds regarding backlogs, denials) reversals.
- I think the Agency is sufficient and continuous updating and enhancements is good.
- Would like to see more CHS time/panels
- Separate breakout & Presentation for Tribes. Tribal specific topics.
- Continue to discuss Federal Regulations, eligibility, & team buildings, exercises, also update on all changes or issues reference to CHS. Training on negotiation contracts w/vendors.
- More information/advice on negotiation of contracts with outside providers
- More training towards Geared Tribes, CHS Contracting average of saving, we should be negotiating for.
- More options in IHS/Tribal Healthcare. Internet forums for Tribal/IHS staff option include a moderator on this.
- CHS only & specific training. Basic sharing among actual CHS staffers.

Customer services, medical priorities, Support - more on reports to help manage funds, etc.

- I don't understand all the PAM - RCIS acronyms
- CHS – Tribal
- Add more Tribal training sessions, breakdowns based on level of experience and job roles. Classes on exactly what type of language can be used to try to negotiate contracts with vendors or just care pricing negotiations. Found it interesting to learn that some tribes can negotiate the care case specifically - awesome - how do we go about this? Coding classes for CHS staff and how we apply that to our jobs. Need Case Management trainings and what each member's role is.
- Separate training information for Tribal. No acronym usage. CHS 101 for new people, new positions and new programs.
- Handouts, visuals, with space for notes. All Area we discussed.
- Workshops where everyone is hand on hand. 3rd Party/AR, Posting - CHS – Report
- Nothing I can think of. Eligibility, CHS priorities, AR, etc - New people - cannot stressed enough.
- How to get contracts with providers. The trainings mentioned in all 4 groups sounded real good.
- Not much improvement needed, maybe speakers from different area; more tribal speakers alongside the IHS speakers. Timely notification from facility to facility of pts. Referred, more on pts. "working the system" how to detect and what can be done?
- Hands on training with RPMS. Workshop with hands on RPMS training ICDIO training, reporting.
- Organized. Staff in sorted staff by New/Advance staff CHS process.
- CHS/trained staff. Better location for training "Exercise Room with coffee.
- CHS 101 & More on Descendents
- Better contact information from Trainers. Specific tribal only topics, (RCIS-Basic) Clinics, Self Services Tribal vs IHS differences.
- Ask how other CHS Programs (Tribal - Compact Title IV & V) would benefit/conduct business w/in their own programs. Wellness training, participants; Tribal leader participants, Medical providers & CHS staff training, Tribal groups. Customer Service Coding. STRESS RELEASE.
- Hand-outs that are actual examples of letters, budget spread sheets, eligibility forms, etc. that are use at various sites.
- Have internet access available prior to session beginning - a couple of sessions access prevented facilitator showing topic.
- A little slower presentation by speakers. CHS eligibility - training providers and patients.
- Hands-on RPMS - to work with actual new patients and show all their abilities.
- Too many of the presenters just read from their handouts on their powerpoint slides. It would have been helpful to expand on these and therefore open up

communication - (Discussion). Pt. registration session only focused on sequencing - not what I expected at all. The presenter did well, though, with the topic.

- A skit of how the whole process works. Ie Patient beginning to end. With the actual patient drama.
- Hone open discussion, round tables, less presentations, would like to see a breakdown of all program & packages with Q&A, scenarios, open discussion from other IHS & Tribal Clinics.
- Acronym training, CHS & IHS training. I am new employee. There is so much I feel overwhelmed.
- More RPMS Training
- Acronym training
- Would like to see native presenters
- Participants want more time for presentations
- Committee members that were called to participate in session did not seem comfortable in leadership role.
- Clayton Old Elk's sessions more relaxed, fun, informative
- Time was limited to cover all the questions that your office requested answers/responses for in the round table break out. Needed more time on the activity.

Break Out Sessions: Tuesday, April18, 2006; 3:00p.m.-5:00p.m.

CHS Strategic Planning and Best Practices
Best practices in Contracting Issue/Negotiating Claims (bills)

1. Establish communications with providers, vendors
   - Set CHS forum;
     - Systems Applications
     - Process and procedures
     - CHS Eligibility
     - Medical priority
     - Frequently Asked Questions
2. Negotiate Medicare rates for Patient medical services
3. Initiate on-site specialty medical services to save CHS funds
4. Tribal consortiums recommend to set lower medical rate

A. The CHS & Tribal CHS coordinators are key players for the above initiatives for the Service Units. Note these key individuals are not limited to the Area Offices, SU CHS Directors, and Tribal CHS Coordinators.

B. Area Office and the Service Unit/Field Staff CHS staff will be directly involved in managing and monitoring the initiatives.

C. To accomplish the initiatives, the CHS program coordinators need to educate and inform the private Providers/vendor and the Area Staff the CHS rules, regulations, the policies and procedures of the IHS referral processes.

D. Patients obtain quality medical care by accessing alternate resources, provide CHS program to serve more patients and ultimately save dollars to assist the medically needy patients.

E. The American Indians/Alaska Natives patient will benefit from these initiatives.

F. These initiatives should be implemented beginning the new Fiscal Year and/or as soon as the new rates are approved.

G. Short range projection is to improve the patient care coordination with the private providers/vendors and the long range plan to assure patients access quality medical services. Set up the CHS program as a patient user friendly system,

The CHS program is intimidating to patients and to the private providers is a complex system. Through the above initiatives these perceptions will change. Each patient will be apprised to ensure patient understand the referral processes. The medical providers will be educated on the requirements for the billing/claims processes.
Not only, will we change the perception, we will initiate changes for the referral system to revolve around the patients, not give patients the "run around" to process the medical referrals. Patient should emphasize on the medical services not medical claims.

CHS Program Issues/Concerns: Group (Federal/Tribal employees)
Moderator: Karla Hall, Larry Tallacus

1. CHS eligibility.
   - Updating the Patient Registration eligibility field.
   - Updating proof of residence
   - Verification of eligibility in the form of documentation from the tribe/BIA.
   - Verification of Social, Economic Ties.
   - Eligibility where, CHSDA?
   - CHS Regulations update.
   - Responsibility for updating, CHS field.

2. Funding.
   - Lack of funding.
   - Projection/cost analysis.
   - CHEF
   - Prior Year funding.

3. Training Needs (Fed. & Tribal).
   - Eligibility (CHS & Direct).
   - Medical Priority.

- RCIS Training.
- CHS RPMS Training.
- Contract/Agreement Training.
- Reconciliation/WebFRS Training.

4. Top 5(6) Recommendations.
   - CHS Workshop.
   - Consistent CHS guidelines.
   - Clearly defined Medical Priorities.
   - ITU inter-communication (CHS Website).
   - Community Education.
   - Denial/Deferred Reporting.

CHS/Customer Service w/in CHS: Top five problems
Moderator: Kim Zillyett-Harris

High Priority
#1) **CHS Website on the IHS home page!!!!!**
- (BO/HIPAA/HER/PCC+ etc have a site why not CHS??)
- CHS manual to be posted here,
- Tribal section for tribes to share letters, brochures
- Best Practices for CHS

* Responsibility for this should be IHS/IT. We think this should be a collaborative effort from both Federal and Tribal sites. It should fit at a National level for users. It should be user friendly for the CHS staff that is daily users of the CHS package. It should be a bulletin board of sorts for Federal and Tribal sites to share information.

#2) **Work closer with providers whether it is: Tribal/IHS/In-house**
- Making sure that the providers have a clear understanding about CHS
- How the dollars need to stretch.
- Making sure the providers understand Priority Level 1.
- When mailing out CHS checks, generate generic letters explaining how CHS works.

* Responsibility for this should be at the local level whether it be Federal or Tribal. Each facility will need to work closely with in-house providers and contracted providers on how the CHS program works. This may take some repetition for contracted providers and in-house providers. This may work best if the sites develop a summary of sorts explaining what CHS is and how it works.

#3) **Patient Education**
- Pt. responsibility-accountability, follow through
- Alternate resource-follow through
- Unrealistic expectations from CHS staff

* Responsibility for this should be at the local level whether it be Federal or Tribal. The CHS staff may need to explain over and over what is expected of the patient. The patient

may not totally understand verbally. The CHS may need to put this is writing for the patient as well as explaining it. Unfortunately there is no real good fix for this, other than repetition for the patient and the CHS staff having great patience with the client.

#4) **Staff Education**

- Staff would like to know how to deal with difficult patients/clients.

*Responsibility for this again is at a local level. There are often times that Federal and Tribal sites cannot afford to send an entire staff to training on dealing with difficult clients. There are training videos available to them through different companies at minimal costs. Fred Pryor has trainings in dealing with customer service. The staff education may have to be presented to staff during lunches by watching Customer service types of videos. There are training magazines available to order from. There are often times On-Line training that staff can take. This sort of education would be nice to place out on the CHS web site showing where CHS supervisors can get this information so they can educate staff in a more effective manner.

#5) **CHS would like to know exactly what the formula is to calculate funding**.

(This is a bit of a loaded question to Headquarters)

- One of the concerns was, we have more patients but no more funding.
- Would like to know exactly how the funding works.
- What is the EXACT formula, not an explanation, but actual showing the formula? (CHS clinic visits + Dental visits + XXXXX = $$$$$)
- Is this calculated the same across the Areas? If not Why Not?

* Responsibility for this would be at each Area. It would be nice to see the exact formula of how this is calculated. Is it calculated the same across the nation and if not WHY not? We would like to see the calculations completely spelled out, not a reason of WHY it is this way, but a complete explanation and a formula of how it got to be this way. We understand inflation, we understand more members on CHS nationwide. But what is not stated is exactly how it works.

<u>CHS Information Needs:</u> What will improve your job performance?
Moderator: LaDonna Cook

Identify top training needs in your program area:
Needs Identified (not prioritized)
*1. Medical Terminology
*2. ICD 9 (Coding in general)
*3. Authorization/training to set up contracts with providers
*4. RCIS training – have been instructed how to enter data but
Complete understanding as to why entered data is necessary
5. Availability of training funding to attend training other
Then local is an issued at most Service Units.
*6. Shortage of Nurses available at Service Units to do Case
Management.
7. Administrative support/physician support when Services is
Denied. (Tribal Council or Health Bond Support needed)

CHS Staffs' need to feel in doing their job.
Administrative/Physicians are going to support decisions made – especially in the referral process.

*8. Patient education – patients need to know the referral Process and expectations of them when referred. i.e. Keeping appointments, length of time referrals is good for.

9. Letter writing skills

10. Availability of updated RCIS manuals. Not all Service Unit/ Field staff are aware of new updates/changes coming down/ Being made to RCIS packages.

11. Loss of revenue – Case Management is a billable Service and Is not being used as such.

* Denotes a more prioritized list, however not necessity an order.

<u>Quality of Care – Case Management</u>

Case Management although a daily activity at the majority of Service Units is not readily identified as such. Lack of Case Management programs to track referrals/emergency room services often lead to payment or non-payment for medical services that are questionable. Shortage of funds leads to staff shortage to focus on Case management staffs are not trained in case management. Billing for Case management appears non-existent; there is a need for working knowledge of case management to ensure a continuity of care.

Group Response to questions:

1. Determine what priority should be placed on the activity you are reviewing: High, Medium, Low

   High

2. List the people or group that should be represented In developing the desired product to address meeting The need of the activity.

   Contract Health Service Staff Case Manager

3. Who should manage the development of the product? CHS-HQ, CHS-Area, CHS-Field, Other

   CHS-Area/Field

4. What action steps do you feel need should be taken in Developing the desired product(s?) Review tools in place.

5. Describe the product(s) that you desire as an output

For addressing the activity.

Case Manager on Staff

6. What customer(s) is the product(s) being developed for?

   ER/Hospitalized patients/Referred patients/Nursing homes if applicable

7. When do you feel the product should be available for use by the IHS?

   As quickly as possible

8. What are the short and long range outcomes that you expect for the activity?

   Not discussed – however, I think the outcome should be better care of Patients and better tracking of referrals and use of CHS funds.