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INSIDE

AHC Media

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With presumptive eligibility, millions converted to Medicaid coverage

Patients 'extremely grateful' — Self-pay patients offered no-interest loans

When an emergency department (ED) patient at Davenport, IA-based Genesis Health System worried aloud how she would pay for a costly medication, the registrar asked her to have a seat.

Within minutes, a financial counselor arranged coverage so the patient could get her prescription immediately. "The patient was extremely grateful," says **Aimee Egesdal**, manager of patient access. "With presumptive eligibility, the patient shows as eligible within 24 hours versus the normal 45-day Medicaid approval time."

> "WITH PRESUMPTIVE ELIGIBILITY, THE PATIENT SHOWS AS ELIGIBLE WITHIN 24 HOURS VERSUS THE NORMAL 45-DAY MEDICAID APPROVAL TIME."

Since the Affordable Care Act (ACA)'s Hospital Presumptive Eligibility Program began in January 2014, patient access employees at Genesis have been able to convert many more self-pay patients to a payer source. "Patients who could not get coverage before are now able to," reports Egesdal. "In 2014, we converted almost $8 million in gross charges to Medicaid coverage."

The Medicaid expansion has greatly reduced the self-pay and underinsured population at Mercy Medical Center in Baltimore, reports **Betty Bopst**, CHAM, director of patient access. "We have also taken advantage of presumptive eligibility," she adds. "Our financial counselors initiate the process with the patients."

Many times, eligibility is determined immediately. "Staff report that patients are very surprised when our financial counselors obtain presumptive eligibility," says Bopst. If approved, the patient has full Medicaid benefits until the last day of the month.

"We have educated patient access staff, case managers, and physician office

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staff about the program," says Bopst. "They all refer patients to financial counselors." The patient access department at Genesis Health System made these changes to convert self-pay patients to a funding source:

• All four financial counselors became certified application counselors so they can help patients to enroll in the Health Insurance Marketplace.

Staff completed online training modules on the Centers for Medicare & Medicaid Services website. "After completing these, they get a certificate, which they display in their office so patients know they're certified," Egesdal explains. *(For more information on the certified application counselor process, go to http://1.usa.gov/1wCxe6f.)*

Registration staff contact the financial counselors if a patient needs assistance, so they can work together. The certification allows the counselors to use a five-question tool to determine presumptive Medicaid eligibility.

"The patient still has to follow up and provide Medicaid documentation, but at least they have coverage for the remainder of that month," says Egesdal.

Patients sign a release allowing patient access staff members to follow up with their case workers and the Department of Health & Human Services. "We assist the patients in filling out any paperwork that is needed," says Egesdal.

Rachel Pai, a financial counselor at Genesis Health System, finds it rewarding to take the stress of financial hardship away from a patient, especially for persons who haven't had health coverage in years. "There were a few patients who would have refused treatment; but with presumptive Medicaid, they were able to get the treatment they needed and get their prescriptions filled," she says.

When patients are approved for presumptive Medicaid, financial counselors also have them apply for ongoing Medicaid and the Iowa Health and Wellness Plan, a program that provides coverage to low-income adults. "Hopefully their ongoing Medicaid will kick in before their presumptive expires," says Pai.

• Patient access leaders work closely with patient navigators who help people in the community with enrollment.

"Helping patients navigate through the crazy insurance world is very rewarding for the staff," Egesdal says. The financial counselors inform the navigators if they're assisting a particular patient so they can work together to find a solution.

EXECUTIVE SUMMARY

In 2014, the patient access department at Genesis Health System used presumptive eligibility to convert almost $8 million in charges to Medicaid coverage. Pre-service teams at Novant Health set up $6.4 million in no-interest loans. Other approaches for self-pay patients:

- Determine eligibility immediately, so approved patients have full benefits until the last day of the month.
- Have financial counselors become certified application counselors to assist patients in obtaining coverage.
- Collaborate with individuals who assist patients in the community.

Recently, navigators helped ED patients to obtain coverage for 10 days during a high-volume period.

"As self-pay patients were being discharged, the navigators offered to help them enroll in a plan on the Health Insurance Marketplace," Egesdal says. "In about 40 hours, 10 patients were enrolled."

$6.4M in no-interest loans

In 2012, Winston-Salem, NC-based Novant Health began a pilot program offering 0% interest loans to self-pay patients.

"We had done interest-bearing loans through a company for many years, but the focus was not on the front end. It was mainly focused on balances after discharge," reports **Craig Pergrem**, senior director of revenue cycle, pre-service, and onsite access.

The pilot program only lasted three months, because it was so successful. "It was so well-received that we opened it up to nine of our facilities," says Pergrem. In 2014, pre-service and onsite teams set up $6.4 million in loans before the patient's arrival.

Patient satisfaction with the program is very high. "Patients have stated they feel we are offering solutions that are 'doable' for them as consumers," says Pergrem.

If patients state that they cannot pay the amount owed prior to service, patient access staff give them the option of the no-interest loan. "We have a plan code that is placed on the account as a secondary insurance," Pergrem explains.

The account goes directly to a vendor who contacts the patient and provides instructions for how to make payments. "Most of the time, we have already established the payment with the patient," says Pergrem. "That crosses over as well, so the vendor knows what payment to put on the account."

All patients qualify for the no-interest loans, with a maximum of 25 payments. "There are exceptions to those terms, but it requires a manager approval for that to happen," says Pergrem.

Recourse rate cut to 10%

There is a cost to Novant Health's no-interest loan program, because it's administered by an outside vendor. "But we saw such a huge reduction of recourse rate, that it is paying for itself," says Pergrem. Previously, the hospital's recourse rate was more than 30%. "With the new plan, it is hovering right at 10%, which is a great number," says Pergrem.

In 2013, the number of payment plans increased by 16%; in 2014, an additional 30% increase was seen. "We are setting up, on average, $1 million a month in payment plans, just on the front end," says Pergrem.

Even though the payment plans are funded immediately, patient access areas can't count these amounts toward their overall point-of-service collection totals. "But we do report it out in our metrics monthly," says Pergrem. "It has helped decrease our bad debt at a time that many hospitals are seeing those numbers increase."

SOURCES

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Making patient access more efficient 'begs for lean principles'

Average hold times cut to under a minute

"Lean" methodology is used for any quality improvement effort in registration areas at Kaleida Health in Buffalo, NY, reports **Diane Pazderski**, RN, director of patient access services.

"Most of this is not rocket science," Pazderski says. "It involves looking at a process step by step."

Three questions are asked: Who does what? Why do we do it the way we do? Where is the opportunity to reduce waste?

Patient access departments easily can become overwhelmed with a project using lean principles, however. At Louisville, KY-based Baptist Health, "oftentimes, simply investigating one issue will give you 10 more opportunities," says **Myndall V. Coffman**, MBA, system director of patient access and scheduling. For example, if you are working with the radiology department to streamline

the MRI precertification process, you'll likely discover a few ways to improve other processes.

"Before you know it, the project keeps growing, and nothing ever gets finalized," says Coffman. "Staying focused on the current process ensures closure."

Top areas of waste

Lean methodology focuses on identifying "waste" in processes.

"Patient access should never cause a bottleneck for a hospital," says Coffman. Here are some examples that Baptist Health's patient access leaders identified in registration areas:

• **Rework.**

"This is one of the main types of waste in access. The do-overs include re-verifying information and correcting errors," says Coffman.

• **Transportation.**

"Many times, hospitals are very spread out," says Coffman. "Patient access departments often utilize too many FTE resources with decentralized registration."

This situation is one form of waste. Another involves patients getting from one area to the next. Patients who aren't ambulatory might need to go to a centralized area for registration, then travel farther to their area of service.

"Streamlining pre-registration processes and using online options, kiosks, and phone call services are some ways to facilitate improvement in this area," says Coffman. *(For more information on this topic, see "Patients expect self-service — Give options: Register online, at kiosk,"* Hospital Access Management*, August 2014, p. 85.)*

• **Computer systems.**

"We are in the process of switching to an integrated system," reports Coffman. "This will offer several opportunities to improve processes that have not been possible until this point."

Currently, patient access staff use eight systems to get their jobs done. "Ensuring that staff have one system, with consolidated forms, is very important," says Coffman.

Single call is made

Recently, Baptist Health Lexington (KY)'s central scheduling department used lean methodology to switch to a "one-call" process.

"We believe that customer care starts at the time of scheduling," says **Ruth A. Patterson**, manager of patient access and scheduling. Patients are scheduled, pre-registered, and informed of any copayment they might owe during a single phone call, instead of being called multiple times.

"Efficiently scheduling and pre-registering the patient in advance decreases the department's abandon call rate and eliminates billing errors," says Patterson.

Before the "one-call" process was implemented, physician offices waited three to five minutes for the next available agent. They now fax orders without calling. "We contact the patient to schedule, pre-register, and inform them of any copayment they may owe," says Patterson. "The average hold time in the department now is less than one minute."

Approximately 300 orders are faxed every week. "This allows us to ensure the order is received up front," says Coffman. "We contact the patient only one time, and we schedule without tying up the phone lines."

Previously, schedulers often scrambled to obtain a compliant order the day before a patient's procedure. Now 100% of scheduled procedures have the order in advance. "Having a compliant order is the key to eliminating billing denials," says Patterson. *(See related story on targeting claims denials using lean methodology, below.)*

SOURCES

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• Diane Pazderski, RN, Director, Patient Access Services, Kaleida Health, Buffalo, NY. Phone: (716) 859-8399. Fax: (716) 859-8655. Email: DPazderski@KaleidaHealth.org. ■

Denials from incorrect information targeted with lean approach — Wasted time cuts satisfaction

Making patient access processes as efficient as possible "begs for lean principles," says **Myndall V. Coffman**, MBA, system director of patient access and scheduling at Louisville, KY-based Baptist Health.

"These principles can be applied for accurate billing, patient scheduling and pre-registration, and patient check-in, to name a few," says Coffman.

Patient access leaders at Kaleida Health in Buffalo, NY, recently used lean methodology to improve the accuracy of pre-arrival information, with the goal of eliminating rework and claims denials.

If on the day of service, the paper

chart includes a piece of incorrect information such as a misspelled name, "we now have to reprint whatever small component remains on paper, along with the consent forms and wristband," says **Diane Pazderski**, RN, director of patient access services.

Wasted time and confusion makes patients dissatisfied with patient access. "It impacts our credibility in the patient's eyes," says Pazderski. "They wonder 'What else did they get wrong?'"

In addition, denied claims often can be traced back to inaccurate information at pre-registration. "Now we have a patient who gets a bill he shouldn't get, leading to further patient dissatisfaction," says Pazderski. The department made these changes:

• Specific staff members are designated to obtain authorizations.

Physician offices don't always provide timely authorizations. "We had multiple inbound and outbound calls regarding a single patient's authorization for a procedure," says Pazderski. "We have carved out a small set of staff to handle this."

An initial attempt is made by pre-registration staff to obtain the authorization. Next, the account is moved to an authorization work queue that a separate group of employees handle. "This group stays with the account until authorization is obtained," says Pazderski.

• A quality audit process was implemented.

"We look at the number of times we receive a denial based on pre-arrival information," Pazderski says. These questions are asked: Was our source of information accurate? How did we determine Medicaid and Medicare eligibility? Do we have accurate databases from our payers?

About 10 registration face sheets are randomly audited per staff member each month by the patient access manager or supervisor at each of the system's four hospitals. "We look at whether information is entered correctly. We also look at denials by staff member," Pazderski says.

One unexpected finding was that eligibility often changed because the first of the month occurred between pre-registration and date-of-service. "This happened more often than we thought," says Pazderski. "We challenge the denial on the backend, but this requires rework and wasted time and effort."

• A new quality management position was included in the 2015 budget.

"We realize the importance of getting it right the first time," says Pazderski. "In order to eliminate downstream rework and waste, we have committed resources to develop a robust quality position."

The position will be dedicated to monitoring and addressing quality issues throughout the revenue cycle, including the pre-registration and registration processes. "We are in the process of developing a job description and onboarding this person," says Pazderski.

• Annual reviews of the registration system were made mandatory.

"We identified that once staff were competent in our registration system, they weren't required to attend a review class," says Pazderski.

They received email notices of changes, but no further formal training. Experienced staff members often turned to new hires to ask about new fields that were added, such as a pharmacy program allowing patients to obtain medications prior to discharge, with the goal of reducing readmissions.

"That was something we needed to address," says Pazderski. "Staff are now required to review the registration system annually."

• Frontline staff share every step they take to complete a process.

"Staff will say, 'Actually, that's not quite the way we complete that step. There are other steps I do before that,'" Pazderski says. Registrars have missing pieces of information that their supervisors can't provide about a process, such as databases they routinely use to find information.

"Managers will often tell you what they think their staff does," says Pazderski. "When you ask the staff, there is much more going on." ■

Payer might claim 'You never sent it!' but patient access can prove otherwise

Automated tools leave no room for doubt

"You never sent it." This response was all too common from payer representatives regarding clinical information that had been sent by registrars at Lawrence (MA) General Hospital.

"Frequently, we have to send clinical documentation to support the admission, whether for observation or inpatient status," explains **Gregory Kanetis**, MPA, director of patient financial services.

At times, registrars fax required clinical information to payers, only to have the claims denied for failure

to provide it. "When payers have their own staffing and processing issues, things fall through the cracks," says Kanetis. "We were continually following up with phone calls to the payer."

At University of Utah Health Care in Salt Lake City, payers sometimes falsely claim they failed to receive the clinical information within the required timeframe. "We have found the issue usually lies with the payer not integrating what we send with the claim in their system," says **John Madison**, supervisor of revenue integrity in the division of Revenue Cycle Support Services.

In this situation, patient access responds by telling the payer representative, "It must be there." "Sometimes it gets the representative to utilize other resources, and they find it," says Madison. "For larger dollar claims, we often use certified mail."

Recently, the department started recording phone calls that the authorization team makes to the payer when checking authorization requirements and obtaining authorizations. "We have had a lot of success with that," says Madison.

The recordings become important when patient access is told authorization is not required, but payment is later denied because authorization was required by their policies. In such cases, says Madison, "the authorization representative at the payer was incorrect, and we are able to prove what we were told using the call recording."

The calls are stored by the employee making the call, with the time, date, and number called documented in the notes, so that managers later can retrieve and listen to the call if necessary.

Registrars at Lawrence General Hospital often struggled to prove they had sent the clinical record. "We had to backtrack, and it was difficult for us to ascertain if and when we actually sent it," says Kanetis. "Maybe we had the fax confirmation, and maybe we didn't."

Even with the fax confirmation sheet, patient access couldn't prove the payer actually received the information. This problem resulted in many claims being denied, which necessitated a lengthy appeals process. Even if denials were successfully appealed, says Kanetis, "it takes an additional 30 days and pushes the A/R [accounts receivable] days out."

No more questions

To reduce claims denials, patient access leaders at Lawrence General "are being aggressive and proactive to get the necessary authorizations in place pre-discharge," says Kanetis.

The department recently implemented a web-based care management tool (Morrisey Concurrent Care Manager, manufactured by Seattle-based MCG). "This streamlines the communication between case management and the admitting benefits counseling staff who manage the authorization piece of it," says Kanetis.

Any clinical records requested by payers now are sent through the automated tool, which logs the exact date and time the information was sent. "There is no question who sent it and when," he says.

Payers' insistence that the clinical record wasn't received created finger-pointing between case management and financial services.

"Each said, 'You didn't send it' or 'You should have notified me more timely,'" Kanetis says. "But it wasn't that we had a bad process. The problems were actually more payer-related."

With good documentation tools, case management and financial services take a collaborative approach if payers don't give the authorization timely. "We are getting the response, 'We didn't receive the records' less often. But that doesn't make the payer respond any quicker," says Kanetis.

Staff are armed with excellent documentation when they call to follow up with payers. "We are seeing fewer 'no authorization' denials," reports Kanetis.

Conflicting information

Conversations about whether an authorization is needed sometimes become debates over "he said/she said."

"We are always battling whether services are medically necessary," says Kanetis.

At times, various payer representatives give different information about what's required for a particular case.

To address this issue, the department is looking into implementing telephone recording software. "This would take the

EXECUTIVE SUMMARY

Patient access departments are seeing claims denials due to payers' inaccurate claims that clinical information wasn't sent timely. Some strategies:

- Implement automated tools to show the date and time the information was sent.
- Use certified mail for high-dollar claims.
- Record phone calls on authorization requirements for specific cases.

ambiguity out of these conversations," says Kanetis. *(See story on how a patient access department achieved a very low denial rate despite increased payer requirements, below, and see ample scripting used to inform patients of out-of-pocket costs, p. 20.)*

SOURCES

- **Gregory Kanetis**, MPA, Director, Patient Financial Services, Lawrence (MA) General Hospital. Phone: (978) 683-4000 ext. 2916. Email: Gregory.Kanetis@lawrencegeneral.org.
- **John Madison**, Supervisor of Revenue Integrity, Revenue Cycle Support Services, University of Utah Health Care, Salt Lake City. Phone: (801) 587-6357. Email: John.Madison@hsc.utah.edu. ■

Department boasts denial rate of just 0.10% even with more payer requirements

It's taking patient access twice as long to get precertifications

Despite increasing requirements from payers, the denial rate at Dublin-based Ohio Health is holding steady at just 0.10%.

"This is a superb number," says **Pam Carlisle**, senior director of patient access services, who says it helped them win the MAP (measure, apply, perform) Award for High Performance in Revenue Cycle from the Healthcare Financial Management Association (HFMA) again. HFMA's MAP keys are performance indicators used to measure revenue cycle processes, financial performance, and patient satisfaction.

Payers are requiring more documentation on reasons for services and supporting materials to show that all other options have been considered. "'Conservative' treatment is a big term coming up with some payers," says Carlisle. This term means that before a patient has a radiology study such as an MRI, patient access needs to show that less costly alternatives were tried, such as therapy, braces, or medication. Only then is the test precertified and paid for.

"It is taking twice as long to get a precertification prior to a procedure, due the increases in clinical documentation," says Carlisle. "As precertification requirements grow, the FTEs needed also grows to handle the volume."

While some plans allow online requests, many plans still require a telephone call.

"The growing payer demands do increase the labor costs for organizations related to securing payment for services," says Carlisle. The department uses these approaches to reduce claims denials:

• Physicians are educated at staff meetings, with lunch provided, on the specifics of what documentation is needed.

"We need to be sure we are capturing all the data," says Carlisle. "Reeducation on payer requirements is a must, as they change so quickly."

• The process of meeting payer requirements is automated.

Questions are put in place to secure specific documentation, such as "Upper or lower quadrant?" "Right or left leg?" or "What specific regions?"

"Asking these clarifying questions can help the documentation be stronger and support the reason for the test," says Carlisle.

• Cross-functional teams meet to review denials related to failure to meet payer requirements.

The team gets to the root cause of the issue and implements a solution for future cases.

"Depending on the size of your organization, you could be risking millions should you not mitigate denials," warns Carlisle.

Patient access leaders at Huntsman Cancer Hospital in Salt Lake City, UT, review monthly and quarterly reports on "controllable" writeoffs. These are writeoffs completed on accounts with denials due to lack of appropriate authorization or certification, non-covered services, and non-medical necessity services.

"More requirements for pre-authorization creates more work for the ordering physicians. There are forms to be filled out and signed, peer-to-peer reviews, and appeal letters," says patient access supervisor **Junko I. Fowles**, CHAA.

All of these requirements cause delays in obtaining authorizations. "We have an effective workflow in place to identify services that require prior authorization, and for these accounts to be worked by prior authorization staff, timely," reports Fowles.

Here are two challenges the department is seeing:

• Some insurance plans won't allow retro authorization if urgent add-ons are performed, such as CT scans of the abdomen or pelvis ordered for cancer patients.

"This most likely will end up in provider writeoffs, since no appeal is available for such denials," says Fowles.

• It is difficult to identify non-covered services and/or non-medically necessary services prior to admission.

"The procedure codes we verify do not require prior authorization and/or covered services per payer guidelines," says Fowles. However, the patients' diagnoses don't always meet the criteria. Often, patient access staff members don't find this out until the claim is denied.

"The solution to this will possibly be creating an edit to identify CPT/diagnosis code combinations for possible denials due to non-covered services," says Fowles.

SOURCES

• Pam Carlisle, Senior Director, Patient Access Services, Ohio Health, Dublin. Phone: (614) 544-6099. Email: pcarlisl@OhioHealth.com. ■

Registrars use this script during pre-registration call

Below is sample scripting written for members of the patient access staff to handle pre-registration of patients at Huntsman Cancer Center, which is based in Salt Lake City, UT:

Financial counselor: Hi, I'm calling from University Healthcare regarding your upcoming endoscopy appointment. May I speak with Mr. Jones?

Mr. Jones: That's me.

Financial counselor: Great. I am calling you to verify demographic information including your insurance benefits before your endoscopy appointment. This will take about five minutes to go over with you. Would you verify your date of birth, current mailing address, phone number, and emergency contact?

Mr. Jones: Sure. It's _____, _____, _____, and _____.

Financial counselor: Thank you. I also show that you are enrolled in Regence Blue Cross/Blue Shield. Is that correct? Do you have any other insurance we can bill?

Mr. Jones: No, just Regence.

Financial counselor: Perfect. I'd like to let you know that we have called and verified coverage for endoscopy with your Regence insurance. There will be no prior authorization required, and it is a covered benefit based on medical necessity. Your out-of-pocket responsibility for this procedure will be about $300.

Mr. Jones: How did you come up with that number? Nobody has asked me to pay for endoscopies in the past.

Financial counselor: Sure, let me explain it in more detail. You have a $250 deductible which you have already met for this year. After you satisfied your deductible, the plan pays at 85% until you meet your annual out-of-pocket of $2,500, of which you have met $1,200 so far this year. Our total billed amount to insurance is $2,800 and the allowed charges is $2,000. Since you will still be responsible for 15% after insurance pays, your portion will be about $300. Will this answer your question? I know it's little complicated. But what's important here is that based on our calculation of 15%, your out-of-pocket amount is about $300, and it is a covered benefit. We are calling patients to inform them of insurance coverage so there will not be any surprises when they receive the bill.

Mr. Jones: I see. So can I pay $300 with you now, or should I bring it with me?

Financial counselor: I'd be happy to take care of the $300 pre-payment on the phone now. It's one less thing to worry when you come in for the procedure.

Mr. Jones: OK. Let me grab my credit card. Hold on for a sec.

Mr. Jones: Here's my credit card number: xxx-xx-xxxx.

Financial counselor: Thank you so much. Let me run your credit card for $300 for your endoscopy. I am sending you the receipt in the mail. Do you have any other questions or anything I can assist you with today?

Mr. Jones: No, I don't think so.

Financial counselor: Thank you for your time, and we'll see you on [day/month/year]. ■

Patients see access and clinical areas as one unit

You know that the real reason a patient had to wait an hour at registration is because the provider's office didn't send the order when they were supposed to. That reason makes no difference to the patient, however.

"Never blame another department, because truly, people see it as one organization," warns **Jennifer Bradley,** director of patient relations at Virginia Mason Medical Center in Seattle. "Patients do not necessarily separate out the nurse who put in their IV from the person who parked their car from the person who registered them."

Instead of fingerpointing, let the clinical area managers know about

the problem so they can address it. "Tell them about the feedback you are getting," recommends Bradley. "Ask them, 'How would you like me to respond?'"

Good communication

Good communication between patient access and clinical areas can head off patient complaints. Recently, one of the health system's clinics had several providers leave the practice and, therefore, suddenly had fewer appointments available. Anticipating patient complaints, members of the clinic staff alerted registration staff members about the problem, and they also informed them that new providers were being hired. "So we were all saying the same thing to patients," says Bradley. She gives these other strategies to improve patient satisfaction in registration areas:

• If patients are unhappy for any reason, have registrars ask, "How can I best help you today?"

Sometimes patients complain about many things that went wrong during a hospital visit. "This question helps patients to focus on what we can do to help them today," says Bradley.

Registrars always can say, "I'm so sorry for your experience." "But don't make promises you can't keep," says Bradley. "It's a mistake to overpromise and underdeliver." Registrars might offer to take care of the patient's parking fee, for example, but promising them an immediate appointment with a provider might not be possible.

• Remember that patients sometimes simply want someone to listen to their concern.

"If a patient has a whole list of problems, you might wonder, 'How the heck am I going to solve all that?'" Bradley says. "It's OK not to have all the answers."

EXECUTIVE SUMMARY

Patients sometimes wrongly blame patient access areas for registration delays resulting from clinical areas. To improve patient satisfaction:

- Avoid blaming other areas of the hospital.
- Ask clinical leaders how to respond to complaints involving their areas.
- Head off complaints with good communication about what clinics are doing to improve access.

Sometimes patients just want assurance that their concerns were heard by the right person. "Once you've assured them they will share the information with the appropriate people, this is often all they wanted. Patients don't always want follow-up," says Bradley.

> "NEVER BLAME ANOTHER DEPARTMENT, BECAUSE TRULY, PEOPLE SEE IT AS ONE ORGANIZATION."

• Tell patients the reason why information is asked for multiple times.

A common patient complaint was "Why do I have to give my name and date and birth over and over again?" Similarly, when patient access staff members at clinics asked about allergies or the name of the patient's pharmacy, or verified patients' medications, patients often became frustrated and said, "I just need to see the doctor."

"Patients see those questions as a barrier to them getting to the clinician," Bradley explains. She recommends telling patients the reason upfront.

Virginia Mason's registrars use this scripting, "We are going to ask you for this information every time you meet somebody new throughout your visit today, and I want to explain why. This is going to set you up for a great visit, because we will make sure your provider has an accurate current history."

'Reading your audience'

• Make patients feel welcome.

Bradley calls this "reading your audience."

"Some retailers do that very well. In healthcare, we are getting better at it," she says.

Patient access staff members tailor their greeting to the patient standing in front of them. If patients look like they can help themselves, staff offer less detailed information. "If they look sad, you don't want to greet them with a bright, cheery hello," says Bradley.

While patients can become frustrated with the registration process, the opposite effect also occurs.

"People get quite attached [to registrars], with some saying, 'I always call this person because they always help me,'" says Bradley. "Sometimes that connection is even more important to them than the provider." *(See related stories on a quality improvement project for registration, p. 22, and what patient access leaders learned from observing over 100 registrations, p. 23.)* ■

Patient access learned these lessons from registration QI project

At Virginia Mason Hospital and Seattle Medical Center, patient access leaders recently did a "kaizen" project involving registration.

Kaizen is a system of continuous quality improvement. Staff members who do the work evaluate and change processes to make work flow more efficiently and improve the overall patient experience.

"We have an average of over 7,000 appointments arriving per week in two different pavilions," says **Darryl Perry**, supervisor of patient financial services. Patients are classified in these ways:

• **Frequent appointment:** For this group of patients who come in several times a month, cycle times (the amount of time it takes to check in a patient for his or her appointment) actually increased from 50 to 70 seconds from 30 to 50 seconds. This increase is because staff identified the need to verify these patients' information.

"We recently discovered that if you come in to see us on the third of the month, we really need to make sure that when you come to see us on the 20th that nothing has changed during that time," says Perry.

In some cases, patients' insurance or demographic information changes between two visits occurring over a short period of time. "We need to capture and update those changes. Otherwise, we will pass along 'defects' into our billing system," says Perry. "We can no longer assume everything's the same."

• **Established patients, who come in once every few months or annually:** Cycle times for this group were cut from 3-5 minutes to approximately three minutes.

• **New patients:** Cycle times previously averaged eight minutes for this group and have been cut to five minutes.

"... IF YOU COME IN TO SEE US ON THE THIRD OF THE MONTH, WE REALLY NEED TO MAKE SURE THAT WHEN YOU COME TO SEE US ON THE 20TH THAT NOTHING HAS CHANGED..."

Here are two things that patient access learned from the kaizen quality improvement project:

• A surprising number of people didn't need to be waiting in the registration line.

First, patient access determined that lines consistently formed during late morning and early afternoon. During these high-volume times, or if a line forms at another time of day, an employee goes through the line and says to each person, "Good morning/ Good afternoon. Are you here to be checked in for your medical appointment?"

About two or three of every 10 patients aren't waiting to be registered and can be re-directed by staff. Many need directions to a patient's room, the cafeteria, or the laboratory. Others just need their parking ticket stamped. "We always knew that there were people in the line that didn't have to be there. We don't want anyone unnecessarily wasting time waiting," says Perry.

• Many patients asked for help with way finding after they were checked in, which added to registration delays.

Registrars often spent several minutes giving patients detailed directions to their appointments. **Jennifer Bradley**, director of patient relations, says, "We are implementing a program so volunteers will take them instead. Our goal is that there is always somebody there to help direct the patient."

The registration process is continuously evaluated to reduce delays. Recently, patient access leaders from a Florida hospital were invited to Virginia Mason for a five-day Rapid Process Improvement Workshop, which is an essential tool in the Virginia Mason Production System, the organization's management methodology. Virginia Mason's patient access leaders asked for their suggestions to stop registration delays.

Perry says, "We said, 'Tell us what we are missing. We want your ideas. You are going to see things that we miss every day.'" The group suggested adding overhead lights to indicate which registrar was free, similar to the process used at some banks and retail stores. They also thought a lobby redesign would improve patient flow.

"Those would have required a massive capital upgrade. But even though we are not able to do those things right now, we still want those ideas," says Perry. "We may be able to use them in the future." ■

Leaders in patient access department observed more than 100 registrations

When leaders in the Patient Family Experience department at Ann & Robert H. Lurie Children's Hospital of Chicago learned that patient satisfaction scores were low in registration areas compared with industry benchmarks, they set out to find out why.

More than 100 registrations at four clinics were observed. "We wanted to identify any barriers that prevent staff from delivering an optimal experience to our patients and families," says **Cara Herbener**, patient family experience consultant.

The team watched how the family was greeted, and they tracked the wait. "We call the observations 'walkalongs,'" says Herbener. "We don't want to give the impression that we are there to criticize or judge."

Several opportunities were noted, including the way the family was greeted. "In our very busy clinics, we sometimes have the tendency to quickly rush through the registration and move on to the next family," says Herbener. Instead of saying, "Welcome Mrs. Jones, we're glad you made it," staff members usually were businesslike and merely told families where to sign in.

To address this issue, staff will attend a 30-minute session with lunch provided, says Herbener. Making eye contact and introducing yourself and greeting the patient with "Good morning," sounds simple enough. "But to be honest, in a very busy clinic setting, this isn't always a natural thing to do," says Herbener. "Often they are just used to getting people in quickly."

Staff were trained to use proper names of individuals, instead of calling parents checking in their children "mom" and "dad," and to use this scripting, "I'm here to check you in. This should take just a few short minutes." The observations resulted in these changes:

• The process to register families in advance of their appointment was improved to eliminate check-in delays.

About one-fourth of families aren't preregistered and need to take care of this issue before they are able to check in. "They had to get out of line, go to a nearby phone, and contact the registration department to complete the registration process, and come back to check in," Herbener says.

A multi-step process is used to ensure that as many patients as possible are preregistered. In many instances, the pre-registration is done at the same time as the appointment is made. "However, sometimes families are not able to stay on the call for this," says Herbener. In these cases, registrars send a letter confirming their appointment and asking them to call to complete the pre-registration process.

Registrars also follow-up with families by phone at least one week prior to the appointment to complete the pre-registration process. "We are attempting even more reminder phone calls to ensure that families get pre-registered," says Herbener.

• Patients can now check in at any station, as opposed to being directed to one particular station.

Patients became frustrated when they had to go to a different place to check in. "The front desk staff were cross-trained so they can check anyone in for any of the outpatient clinics," says Herbener.

• Staff members were trained to handle difficult situations as they arise.

Patient access managers saw these situations occur often during the observations:

— A family has been waiting 30 minutes or more past their appointment time.

"People get pretty frustrated and want to know what's going on," says Herbener. Instead of dodging the issue, staff are encouraged to be upfront about it. Registrars tell families, "To be honest, we are running about 30 minutes behind. If you'd like to occupy your time, please feel free to visit our fire truck on the 12th floor or the beautiful sky garden on the 11th floor."

"For extreme delays, we offer vouchers for our cafeteria and/or parking," she says.

— A family shows up on the wrong day.

One family realized that their appointment was for the previous day after driving for several hours. The provider they were scheduled to see wasn't in that day. "Unfortunately,

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they couldn't be seen," says Herbener. "A better approach would have been to call back to the nurse and ask if any other doctor could see the family."

— A family arrives for their appointment and discovers that the hospital is no longer covered by their insurance plan.

Often, families have waited months for an appointment. In this difficult scenario, says Herbener, "we offer to see them but take time to explain that the visit won't be covered by their insurance."

It is better to prevent this frustrating problem from occurring in the first place. "We have done quite a few things to make sure this doesn't happen," says Herbener. "About 75% of patients are now preregistered, so if their plan is out of network, they are informed in advance." ■

Negative consequences abound when nonprofits sue the poorest

Nonprofit hospitals receive a tax-exempt status based on their work to serve the poor by addressing their medical needs. However, the medical billing practices of hospitals recently were called into question by a Consumer Financial Protection Bureau report, according to the National Association of Healthcare Access Management (NAHAM). *(To view the report, go to http://1.usa.gov/1umJmpZ.)*

The report examined medical debt in this country and found that 1 in 5 consumers, or 43 million individuals, have a negative mark on their credit report from a medical debt. The debt collections practices employed by hospitals raise several concerns including releasing private medical information covered by HIPAA to outside parties not involved in treatment, unfair billing practices that disproportionately impact low-income patients, a failure to provide and educate patients on available aid, the need for aid to retroactively cover eligible medical costs, and the legality of nonprofit hospitals suing their poorest patients.

A recent NPR story highlighted the issues that arise for low-income patients when nonprofit hospitals sue for unpaid medical bills, NAHAM said. *(To view the NPR story, go to http://n.pr/1AGp81K.)* In addition to the arbitrarily higher prices that many low-income patients are charged for medical treatment, the debts associated with their medical care negatively impact nearly every area of their lives. Medical debts reported to credit agencies lower credit scores which, in turn, raises the prices for many basic needs such as car insurance, mortgages, credit cards, and loans. Additionally, some employers examine the credit report in the hiring process. A low credit score or history of medical debt might negatively impact individuals' opportunities to obtain jobs because they are viewed as irresponsible or the employer thinks they will not be reliable due to the medical issues insinuated in the report.

Resources to help those with medical debt may be found at the following websites:

- **Legal Aid.** Web: http://bit.ly/1zhGxyF.
- **Families USA.** Web: http://bit.ly/1wdwqDO.
- **National Consumer Law Center.** Web: http://bit.ly/1BvXncF.
- **USA.gov.** Web: http://1.usa.gov/1tKIGvJ. ■

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