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Integrated systems are top priority — Dramatically improve efficiency

Rework, incorrect information, and claims denials are primary problems

It’s one of the biggest time-wasters in patient access: Employees are constantly switching back and forth between many different systems, just to do their jobs.

“For the last decade, we have talked about clinical system integration and meaningful use requirements. But we have neglected a focus on revenue cycle integration,” says **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Experian/Passport Health, a provider of technology for hospitals and healthcare providers.

When patient access systems aren’t integrated, information is outdated and sometimes incorrect. “Disparate and missing information across the enterprise is the monster you have to wrap your arms around when patient access is working with a lack of integration,” says Murphy.

Manual entry of the same information over and over causes dissatisfied patients and increased claims

denials. “With the advent of patient engagement buzz, meeting consumer expectations, and a decrease in reimbursement, integration is certainly a key to success,” says Murphy. (See related story, p. 27, on revenue cycle software paired with integrated systems.)

In October 2014, two hospitals in the Western Connecticut Health Network integrated their systems, including those

used by patient access areas.

“Prior to that, we were on all different platforms for every single system,” says **Judith Nicolosi**, CHAM, director of patient access for the health system, which includes Danbury Hospital, New Milford Hospital, and Norwalk Hospital.

Six months before the integration went live, Nicolosi identified five



“WE NEEDED TO FIND A SOLUTION WITHOUT A BIG PRICE TAG.”
-- **SUSAN LABOW**, INTERIM EXECUTIVE DIRECTOR, REVENUE CYCLE, KERN MEDICAL CENTER

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patient access employees — about a third of her staff — who were most enthusiastic about switching to the new system. “They became the experts. They had an intricate level of understanding on how the systems worked,” she says. “That piece was so important.” These employees then trained their patient access colleagues, so they were comfortable working on the new system well before the go-live date.

The third hospital in the health system still isn't integrated. Patient access employees also still need to use multiple applications within the two hospitals that are integrated.

Still, the change made patient access processes much more efficient. “It's one sign-on when we go into any application,” says Nicolosi. “Now we all talk the same language.” Previously, patient access staff at the two hospitals used different terminology for insurance codes.

Staffing is more flexible, because registrars can easily switch back and forth between hospitals. “We can have a staff member work at the other hospital if they're in a staffing crisis, because they already know the system,” says Nicolosi. “We were not able to do that before.”

Patient access leaders at Bakersfield, CA-based Kern Medical Center had a frustrating problem: Surgery scheduling was not done in the same module as preoperative testing.

“We had to find a way to gather all the schedules for every single visit and create a flow to ensure that all tasks were completed,” says **Susan Labow**, interim executive director of revenue cycle. Labow also is vice president of Receivables Optimization Inc., a Long Beach, CA-based consulting firm specializing in revenue cycle improvements.

Pre-registering, verifying insurance, obtaining authorizations, and collecting patient liability needed to occur prior to the patient's arrival. Also, patient access needed to notify clinical areas if a patient was scheduled for surgery but wasn't scheduled for preoperative testing. “We needed to find a solution without a big price tag,” says Labow. (*See related story, p. 28, on other improvements made in the hospital's patient access areas.*)

One obstacle was that patient access used three systems for the electronic medical record (EMR), registration, and scheduling. Patient

EXECUTIVE SUMMARY

There is increasing need to integrate systems used by patient access departments within organizations, and also within hospitals in the same health system, to prevent rework, incorrect information, and inefficient processes.

- At Western Connecticut Health Network, a small group of enthusiastic patient access employees were trained six months before the “go-live” date of the newly integrated system.
- Registrars can work at multiple hospitals if they share the same system.
- Patient access leaders at Kern Medical Center found a low-cost way to put surgery scheduling in the same module as preoperative testing.

access manager **Helen Cullen** says, “There was no way to get the three platforms to talk to each other. Our EMR is somewhat archaic, adding to the confusion.”

When a physician entered an order into the system, the referral department couldn’t see it if it was first opened by someone else, such as a nurse in the provider’s office. “Because of this system limitation, if somebody other than the referral department opened the notification, there was no way for the referral department to even know it exists,” says Cullen.

The biggest issue involved patients scheduled for surgery. In some cases, the patients already had appointments at clinics for preoperative testing. “It was so frustrating, because we couldn’t see that,” says Cullen. The patient would show up on the surgery schedule, which meant patient access needed to obtain an authorization. However, patient access had no way of knowing if the patient was scheduled for their preoperative testing.

Cullen took a night class at a community college to expand her knowledge of the department’s Microsoft Access Database program. Working with the hospital’s information systems department, Cullen found a way to make the orders accessible to patient access. They’re now moved directly into a

table that she created. “I was very surprised that something so simple worked. Why didn’t we think of this before?” says Cullen.

When patient access employees submit an authorization, a spreadsheet opens up. “That form is the face of what’s really going on behind the scenes,” says Cullen. Staff easily can view all of the authorization requests they need to follow up on.

“What is really nice is we don’t have to be dependent on other departments for information. We just have it,” says Cullen.

Previously, Kern’s patient access staff couldn’t see the patient’s insurance information without going into a separate registration system.

“We had the patient’s last payer information pulled into the Access database, as a starting point,” says Cullen. “At least we know what insurance company to verify eligibility for.” This system greatly reduced denials for claims billed to the wrong payer or for a patient who no longer had that coverage.

The most recent information now comes up, and “99% of the time it’s correct. We just validate it and submit. It’s a lot quicker,” says Cullen. “It’s one less step for us to take.”

Staff members now can sort authorizations by insurance payer, which allows them to consolidate calls and spend less time on the phone. “Previously, staff would call payers for

one patient at a time,” says Cullen.

Data is fed from the EMR, registration, and scheduling systems into the Access Database table used by patient access, and it is continually updated. “Staff submit the request for authorization to the payer using one form. Once it’s submitted, they use a follow-up form,” says Cullen. If the authorization is obtained, it goes off their view and doesn’t pop up again.

“Physician offices can see that the authorization is obtained and that surgery is OK to schedule,” says Cullen. “Before, the other departments had no way of knowing it was approved.”

SOURCES

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Even integrated systems may need specialized revenue cycle software

Integrated systems can solve many dilemmas for patient access by creating work lists for error management and allowing staff to determine eligibility in real time.

“But they are not a panacea,” says **Katherine H. Murphy**, CHAM,

vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Experian/Passport Health, a provider of technology for hospitals and healthcare providers.

Hospitals sometimes expect the integrated organization-wide system

will solve all of their revenue cycle problems. “But many still need additional outside platforms to manage the revenue cycle process,” says Murphy.

Often, patient access leaders worry that they will have to work

in two places: the integrated hospital information system (HIS) and the other platform. “However, when they see how easy this is, and the benefits and additional streamlining this creates, they quickly stop their worrying,” says Murphy.

Some hospitals are implementing, in addition to their integrated system,

revenue cycle software programs that provide integrated platforms. These software programs allow a single sign-on for all revenue cycle applications. “They offer real-time integration intelligence that the big box systems do not,” says Murphy. Such platforms can automate the updating of insurance code errors

and information flowing from one application to another, for example.

“The platforms can actually take the electronic order and have that information flow across to registration, medical necessity, eligibility and address checking, preauthorization, and estimates,” says Murphy. ■

Department sees ‘record high of cash collections’ and fewer accounts receivable with these changes

In Fiscal Year 2014, patient access leaders at Bakersfield, CA-based Kern Medical Center reduced the billed accounts receivable (A/R) from \$82,000 to \$56,000. “And we didn’t simply write off the A/R,” reports **Susan Labow**, interim executive director of revenue cycle.

In addition, says Labow, “We doubled our cash flow from September 2013 to September 2014, with 40% less staff, and reached a record high of cash collections.”

To reach this accomplishment, Labow assessed all of the hospital’s registration functions in the emergency department, inpatient, and surgical settings. These changes were made:

- **The department instituted mandatory securing of authorizations during the scheduling process.**

“This reduced the amount of services rendered without authorization,” says Labow.

- **A process was developed to clean up a large backlog of surgery authorizations from case management.**

“Once cleaned up, it was incorporated into the regular pre-registration flow. We moved this responsibility to Patient Access Services,” says Labow. Patient access secures the authorization, validates

eligibility, and resolves the patient’s liability, all before the patient’s arrival.

- **A pre-registration process was implemented, to be completed five days prior to surgery, including authorization, insurance benefits, and patient liability resolution.**

“Patient access absorbed responsibility for all registration and authorization processes for diagnostic services,” says Labow. “This was formerly handled by the hospital’s clinics.”

- **Job functions were re-aligned in patient financial services.**

A decision was made to outsource Medicare follow-up and commercial claim submissions. “Revenue is 75% Medi-Cal, 8% Medicare, 10% managed care and commercial, and 7% self-pay,” says Labow. FTEs were reduced from 27 to 14, including two supervisors, with employees assigned to these areas:

- One FTE handles commercial insurance follow-up.

- One FTE handles underpayment review and payer escalation efforts.

- One FTE processes and resolves state Medi-Cal revenue.

- One FTE processes state-sponsored Medi-Cal Managed Care revenue.

- Two FTEs handle hard copy claims and attachments, and they

handle requests from attorneys for records and itemized bills.

- One FTE is the hospital liaison between self-pay vendor and hospital.

- Five FTEs perform payment processing.

“We outsourced self-pay to proactively contact patients, eliminate mail return, and resolve debt,” says Labow.

The department’s claims editing vendor (MDX/MAX II, manufactured by Long Beach, CA-based Medical Data Exchange) resubmitted all Medi-Cal accounts that had not been paid due to inefficient edits by the hospital’s previous claims editing vendor. “We developed numerous edits and programming with MDX to increase clean claim percentage and decrease the need for manual intervention,” says Labow.

Because state programs have a very low reimbursement, it is not cost-effective for staff to work on these claims, she explains. “Medi-Cal and Medicare claims are now generated, submitted, and paid without human intervention,” says Labow.

On the other hand, commercial claims continue to require follow-up even if patient access submits a clean claim. “That’s where you have to focus your staff efforts: dialing for dollars,” says Labow. ■

New task force aims to revamp revenue cycle with a 'patient-centric' focus

Group is planning 'financial experience of the future'

When payers, providers, revenue cycle vendors, consultants, and financial institutions met to discuss the next generation of revenue cycle management processes and tools, there was a surprising amount of agreement.

"It was very encouraging to see how quickly the participants coalesced around what the future of revenue cycle management should look like," reports **Pam Jodock**, senior director of health business solutions for the Healthcare Information and Management Systems Society (HIMSS). The HIMSS' Revenue Cycle Management Task Force is a multi-year project that's addressing coming changes in the revenue cycle.

"We are looking at what we believe the patient financial experience of the future should be," says Jodock. "The center of that vision is what we are referring to as a healthcare information hub, for lack of a better term at the moment."

This vision assumes that electronic health information will be freely exchanged between all parties. Individuals would be able to research their benefits, determine the eligible providers, schedule appointments, and address all their financial concerns upfront.

"At the end of their first visit, they would have the opportunity to sit with someone to determine the next step of their care, schedule it, and also make payment arrangements," says Jodock.

Front-end processes — patient access, business analytics, and point-of-service collections — are a key

focus for the task force. **Zubair Ansari**, MHA, director of patient financial services at Johns Hopkins Medicine International in Baltimore, MD, says, "With an increasing shift from a traditional managed care population to newer economies of scale where consumers are more price-sensitive and utilizing real-time tools and technology, it is imperative we engage patient access leaders throughout the country."

Here are three key issues identified by the group:

- **Updated technology is needed.**

Jodock says, "It may be a matter of introducing new technology, or improving on legacy systems if that's cost-prohibitive."

- **Data security is a major challenge.**

Today, information is not shared openly between payers, financial institutions, and providers. "Building those systems in a way that allows timely exchange of data, while at the same time protecting an individual's personal health information, is going to take time and a lot of cooperation," says Jodock.

- **There is a paradigm shift**

in healthcare toward a more "consumer-centric" focus.

"It's not just about the business needs of a particular stakeholder group," says Jodock. "At the end of the day, we all have the same customers, and we are all interested in patient satisfaction."

One-stop shopping

John Showalter, MD, chief health information officer at The University of Mississippi Medical Center in Jackson, says the patient-centric vision developed by the task force will "empower patients to make better and more informed healthcare decisions, while increasing convenience and streamlining payment for healthcare services."

The goal is for individuals to access all of their financial and health information on one site, without having to toggle between insurance carrier, provider, and financial institution websites as they do currently. Jodock says, "This information hub would facilitate the communication between the various parties and give the patient a one-stop shopping experience."

EXECUTIVE SUMMARY

The Revenue Cycle Management Task Force of the Healthcare Information and Management Systems Society is addressing the next generation of revenue cycle management processes and tools. Payers, providers, vendors, and consultants are involved.

- Front-end processes such as patient access, business analytics, and point-of-service collections are a key focus.
- Patient access will need new technology or updated legacy systems.
- Patients will be able to manage their care with a single portal.

Patients search multiple portals to get information in bits and pieces. In some cases, information isn't available at all to the patient. "The intent is to develop a revenue cycle management process that supports all players equally," says Jodock. "It must focus on cost containment, quality improvement, and be consumer-centric."

It is much harder for patients to access information than it is for providers or payers. The task force wants to change that level of difficulty.

"It shouldn't be harder for me, as a patient, to access information and

participate in the revenue cycle," says Jodock.

Fee-for-service payment methodology is one reason it's so complicated to tell patients what their care will cost. Because providers are paid on a piecemeal basis, it's impossible for the payer to predict what the total episode of care is going to cost.

"But if reimbursement is more focused on quality of care and outcomes — with medical homes and bundled payments, for example — it changes the way the insurer pays for care," says Jodock. "It makes it easier to anticipate the patient's

responsibility."

SOURCES

- **Zubair Ansari**, MHA, Director of Patient Financial Services, Johns Hopkins Medicine International, Baltimore, MD. Phone: (410) 464-6455. Email: zansari1@jhmi.edu.
- **Pam Jodock**, Senior Director, Health Business Solutions, Healthcare Information and Management Systems Society, Chicago. Email: pjodock@himss.org.
- **John Showalter**, MD, Chief Health Information Officer, The University of Mississippi Medical Center, Jackson. Email: JShowalter@umc.edu. ■

Median wait time for appointments cut from 25 to 13 days by patient access

Patient access leaders at Seattle (WA) Children's Hospital reduced the median wait times for new patient appointments from 25 days to 13 days.

"Our goal for Fiscal Year 2015 is 11 days," reports **Jennifer Becker**, vice president of ambulatory services.

In 2008, which was the first year of the project, there was a seven-day decrease. "At first, there is much more low-hanging fruit," says Becker. "But when you get down to about 15 days, it becomes exponentially more difficult to take one day off."

The department made these changes:

- **Each week, patient access works with various service lines to open up new capacity as needed.**

In some cases, this change means adding nurse practitioners, physician assistants, or faculty physicians. Service lines aren't always able to respond to the demand for more capacity, however.

"That's a challenge we are working through," says Becker. "We're working

on a model of flexible physician deployment." This model allows clinics to meet changes in demand, such as by physicians extending their hours on a given day.

- **The process for making appointments is simpler, with fewer scheduling rules.**

"We had a very complex set of scheduling rules, to match the patient with the perfect appointment. That was problematic for many reasons," says Becker.

Slots were left unused when providers had cancellations, if the provider wasn't the exact type of specialist a patient needed to see. In some cases, patients would have been

happy to get a quicker appointment with the provider, but schedulers couldn't book the appointment according to rigid rules.

"Most would rather get in and get started quickly, rather than wait for a certain subspecialist," says Becker. With fewer scheduling rules, these slots are now available.

- **Primary care physicians now refer patients immediately.**

Providers were required to fully "package" patients before referring them.

"The physicians did not want to do that," says Becker. "They preferred to have families call and schedule right away."

EXECUTIVE SUMMARY

Patient access reduced the median wait time for appointments from 25 to 13 days at Seattle Children's Hospital. These changes were made:

- Scheduling rules were simplified.
- Senior leaders now approve all exceptions to the four-hour time block standard for physicians.
- A data analyst position was created.

Previously, families waited up to seven additional days for an appointment, depending on how long the provider's office took to refer them. "We typically think about access wait times as starting from when the patient first contacts us," says Becker. In fact, families had lengthy waits before they were even able to call for the appointment. Patients are now able to schedule right away, "and we do the prep afterward," says Becker.

- **"No shows" were reduced by sending reminders closer to the family's appointment time.**

"The lead time for reminder calls was reduced from four days to three days," says **Sarah Thomas**, director of patient access. "We also reduced the lead time for reminder letters from two weeks to one week."

- **Families were surveyed to determine demand for same-day access.**

The general surgery team offers same-day access, but the median wait is still about six days. "It's not because they don't have capacity. It's because that's what some families are choosing," says Becker.

Patient access surveyed families and learned that 24% preferred to schedule appointments more than 14 days out.

"Some need more time to plan because they need to travel here. Or they may need to coordinate with their work schedule. We don't have evening hours for every specialty," Becker explains.

Patient access leaders contacted representatives from AmazonFresh and learned that in order to meet same-day delivery commitments for groceries, a certain amount of capacity is left open every day. "It's the same in healthcare," says Becker. "We know we need to leave some capacity open. We are trying to

understand how to balance this with cost."

- **Senior leaders now approve all exceptions to the four-hour time block standard for physicians.**

Previously, individual physicians sometimes requested shorter blocks of time. Office managers had to attempt to enforce the four-hour standard. "It's a challenging place to put your middle management," says Becker. "We needed to take them out of it." (See related story, below, on a new data analyst position created by the patient access department.)

SOURCES

- **Jennifer Becker**, Vice President, Ambulatory Services, Seattle (WA) Children's Hospital. Email: jennifer.becker@seattlechildrens.org.
- **Sarah Thomas**, Director, Patient Access, Seattle (WA) Children's Hospital. Email: Sarah.Thomas@seattlechildrens.org. ■

New position of data analyst gives information patient access can act on

At Seattle (WA) Children's Hospital, a quality improvement analyst position was created just for patient access.

"He's embedded within the operational team, so he has a clear understanding of our data and local software," says **Sarah Thomas**, director of patient access. "He quickly translates our data needs into his technical databases and tools."

The analyst often generates same-day reports to answer key strategic and operational questions. Because the department already has made many changes to improve efficiency, however, there is no more "low-hanging fruit." This efficiency makes continued improvement more challenging. "We've got to really dig

into the details to understand the correlation in our variables," says Thomas.

The department uses data visualization software from Seattle-based Tableau Software to create graphs and charts. "It gives us such a great tool for dicing and slicing the data to better identify improvement opportunities," says Thomas. The data analyst taught the patient access management team how to use the software to improve their departments.

"The data visualizations display supply and demand, and track progress over time," says **Jason Chang**, the department's quality improvement analyst. The visuals highlight areas in need of

improvement, and they allow leaders to monitor progress. Here are some ways the department benefits from the data analyst position:

- **A dashboard is updated weekly to provide visuals to show how well the department is performing.**

"This is helping us better understand each other's needs and the impact of our efforts," says Thomas.

- **The data analyst acts as a conduit to the hospital's information technology partners.**

"He understands the language of databases and reporting at an infrastructure level, not just the reports that we as management are trained to use," says Thomas.

- **Better data allows patient access to balance the demand for**

specialty services with the capacity in the system.

To predict wait times, patient access needs to know how many slots are open and how many referrals there are. **Jennifer Becker**, vice president of ambulatory services at Seattle (WA) Children's Hospital, says, "Making that visible has been a really important body of work."

Recently, the data showed a drastic spike in referral volumes for a specific specialty. "Seeing this new demand raised the question of what was happening in the landscape of the

specialty," says Chang. He discovered that an established specialist in the community had retired, which resulted in a flood of patients seeking care. "Seeing the data week to week helped to identify abnormalities in referral patterns for the specialty. It assisted in the preparation for the unexpected demand," says Chang.

One clinic wasn't routinely filling its appointment slots, measured as a percentage of utilization, but it still had access delays of several weeks. "The clinic head was feeling frustrated that the measure might be wrong or

that maybe we weren't being effective in scheduling," says Thomas.

Data revealed that one provider was bringing down the group's average.

"This allowed the chief to focus her efforts on expanding the training of that provider, improve access for their patients, and bring up their utilization," says Thomas.

SOURCE

- **Jason Chang**, Quality Improvement Analyst, Seattle (WA) Children's Hospital. Phone: (206) 884-2814. ■

Two-deep cross-training keeps patient access from being short-staffed

Few patient access applicants at Cottage Hospital in Woodsville, NH, have a strong background in registration and insurance. Many have never even worked in the hospital setting. Finding qualified per diem staff is also not easy.

"It is hard to find individuals who are just looking for per diem in today's economy," explains **Jennifer A. White**, director of patient access. "Two-deep" cross-training has solved both of these problems.

"We find that it is crucial that each ancillary department have two additional registrars trained to cover during a scheduled or unscheduled absence," says White, who supervises ancillary office staff such as rehab, radiology, the emergency department, specialty clinics, surgical, and ambulatory care. These steps are taken:

1. Seasoned registrars who are experienced with software and scheduling are sent to an ancillary department for two weeks of training.

"The training in ancillary departments consists of their internal workings and departmental

processes," says White. In radiology, for example, training covers entering orders, prior authorization, daily reports, and requirements for each exam.

2. At the end of the two weeks, the registrars work independently in the ancillary department.

3. The ancillary registrar is moved to the patient access department for cross-training, or for skill-building if he or she already is trained.

"The ancillary registrar does not register patients on a daily basis. The philosophy 'use it or lose it' is true," says White.

To keep skills of cross-trained staff current, she sometimes schedules

the backup registrar to work in the ancillary department. The registrar from the ancillary department works in patient access for the day. "By flipping seats once or twice a month, they are not just placed in the department during limited time off throughout the year," says White.

This system keeps both registrars current on any changes in the department they're covering, such as authorization requirements. "It is challenging for someone to be a backup and only cover once or twice a year," says White. "They cannot be expected to perform at their best when they have not been given the tools to stay current." (*See related*

EXECUTIVE SUMMARY

Two additional registrars are cross-trained to cover absences in ancillary departments at Cottage Hospital. At Cooper University Hospital, registrars also work at the patient information desk.

- Experienced registrars are trained for two weeks before working independently.
- Backup registrars keep skills current by working in each other's departments once or twice a month.
- Monitored cameras allow registrars to assist when long lines form.

story, p. 33, on how cross-training has benefited the department.)

Reception staff at the patient information desk at Cooper University Hospital in Camden, NJ, are responsible for greeting patients and visitors. They also supply passes to patient's rooms, provide wayfinding throughout the campus, contact patient transport as needed, and perform various other duties.

"Our challenge was to balance staffing with that of expected visitor flow, in order to prevent long lines from trailing through the lobby. This was not an easy task," says **Randy Smailer**, manager for patient access quality assurance at The Cooper Health System.

If they saw too many idle receptionists, hospital administrators raised questions about overstaffing.

On the other hand, understaffing resulted in long lines and dissatisfied patients. "Our solution was to combine cross-training with technology," says Smailer.

Managers asked seven patient access insurance specialists, who were stationed near the information desk, whether they were interested in cross-training. Four agreed. "This provides them with the opportunity for overtime if the situation arises where their services are needed," notes Smailer.

The four patient access employees worked alongside the information desk receptionists until they felt comfortable on their own. A camera was installed that focused on the queue area in front of the information desk, which allows a nearby patient access manager to monitor

line volumes. "At the first sign of congestion, assistance is dispatched to the information desk. If congestion continues, more relief is sent," says Smailer.

It's now very rare for hospital executives to express displeasure over long lines in the lobby.

"Elimination of wait times always results in an increase in satisfaction," says Smailer.

SOURCES

- **Randy Smailer**, Manager, Patient Access Quality Assurance, The Cooper Health System, Camden, NJ. Email: smailer-randall@cooperhealth.edu.
- **Jennifer A. White**, Director, Patient Access, Cottage Hospital, Woodsville, NH. Email: jawhite@cottagehospital.org. ■

Cross-training gives these benefits at no cost

Patient access areas at Cottage Hospital in Woodsville, NH, have seen these benefits from cross-training:

- **Coverage usually can be provided at no additional cost to the department.**

"We try to remain budget neutral as much as possible, but that is not always an option," reports **Jennifer A. White**, director of patient access.

Staff members clock into the department they are being cross-trained for, which is an additional expense. "But if we can cover the department the trainee came from

without calling in coverage, then we can remain neutral," says White.

- **Employees feel more valuable to the team, which helps reduce turnover.**

"Two of our employees have been in patient access for 14 years," says White. The newest employee has been there for a year. Other employees range from three to seven years.

White attributes the department's low turnover rate, in part, to cross-training and the opportunity for advancement that it represents. "In order to start advancing past the Registrar 2 Level in the department's

Registration Ladder, staff need to be cross-trained," she explains. To advance to the Registrar 3 Level, employees need to be cross-trained in at least three departments.

"It is not easy to put a monetary value on our savings, but it boosts staff morale," says White.

- **Patients don't have to deal with an employee filling in who isn't adequately trained.**

"It is seamless to the patient when someone is out, whether scheduled or unscheduled," says White. "Patients do not see a breakdown, and it does not affect patient flow." ■

Report on hospital discharge planning tools

Hospital discharge planning tools should incorporate the judgment of clinicians and be administratively feasible, according to findings in a new report released by the American Hospital Association

(AHA).

The report highlights lessons learned from five hospitals and health systems that developed innovative tools aimed at improving patient care transitions. The five tools support

decision-making related to when a general acute-care hospital patient should be discharged, whether a patient will need post-acute care, and what types of post-acute care might be most suitable.

While their primary objectives vary, the tools have three cross-cutting themes: appropriate post-acute care placement, readmission reduction, and management of patient transitions from acute to post-acute

care settings. Each of the tools was designed to align with the culture of the organization and providers using it, with a focus on reducing the burden on administrative staff and clinicians.

AHA convened a technical advisory panel of members and other stakeholders to examine a variety of innovative patient discharge planning tools. *(To access the report, go to <http://bit.ly/1DjaM8U>.)* ■

Were access staff really as rude as caller claims? Recorded calls will give you an answer

Members of the patient access staff at Mission Hospital in Asheville, NC, weren't too happy to learn that every incoming and outgoing phone call would be automatically recorded. However, their opinion changed dramatically after a few months.

"It has saved them, quite a few times," says **Lee Anna Mull**, manager of patient access. Calls are retrieved and listened to if a complaint is made. *(See related story, p. 35, on how recorded calls can be used for quality improvement.)*

At times, irate patients complain to Mull about rude treatment. When she listens to the call, it turns out the patient was the one who spoke disrespectfully. "Typically, once you tell them that all calls are recorded and that you listened to the call, they tend to chill out," says Mull.

The same is sometimes true of providers. In one case, a physician complained that patient access was rude. "When I told her we listened to the phone call, she told me that the financial counselor was not rude to her at all, and that she was the one who was rude," says Mull.

Patient access learned these things from the recorded calls:

- **Some employee began without a greeting, saying simply, "Scheduling, this is [name]."**

Scripting was changed. Employees are now expected to say, "Good morning, this is scheduling, this is

[name] speaking."

- **Some employees were scheduling services at the wrong location.**

"Certain types of appointments and therapists are only available at one location," says Mull. Guidelines were updated to reflect this. For example, some therapists can see patients only at a certain location for physical therapy.

- **Some employees were picking the wrong type of appointment repeatedly.**

For example, many routinely scheduled CT scans with contrast for patients who were allergic to contrast. This scheduling sometimes caused delays when the patient arrived for the test.

"That sent up flags that education was needed, not just for that employee, but for the entire staff," says Mull. Managers provided one-on-one training or group refresher

courses. "We also updated guidelines to help instruct the schedulers to make sure the correct appointment was chosen," says Mull.

Some recorded calls revealed that the incorrect information on the test had been given to patient access by the provider's office. "That gave me the opportunity to reach out to the office, to improve on future processes," says Mull.

Estimates are just that

The most common patient complaint is that they were given incorrect estimates by financial counselors. One patient complained, "They told me I had to pay upfront or they'd cancel my surgery."

Mull listened to the call and learned that the employee said nothing of the kind. However, she encouraged financial counselors to emphasize to future callers that non-payment would not cause surgery to

EXECUTIVE SUMMARY

By recording phone calls with patients and providers, patient access managers can determine whether complaints about rudeness or incorrect information are valid. Here are changes made at Mission Hospital:

- Scripting was changed for greeting of callers.
- Employees were educated to avoid scheduling CT scans with contrast for allergic patients.
- Guidelines were made clearer about each specific location and appointment type.

be cancelled.

In responding to patients who complained about an incorrect estimate, Mull takes a businesslike approach, to explain why the estimate and the patient's out-of-pocket costs differed. Sometimes, this difference is because when the patients originally called for the estimate, they told the employees they were having a certain procedure, but additional procedures ended up being done. Staffers always explain that taking care of the account before the date of service will speed the check-in process.

"A lot of people don't know their insurance and think the hospital is just out for money," says Mull. "We've had to educate the community."

Calls protect access

At times, recorded calls reveal opportunities for patient access staff to improve, says **Alexander Wemyss**, MBA, CHAA, supervisor of customer service at Sarasota Memorial Hospital. However, staff members take comfort in being recorded.

"In most cases, the calls end up protecting patient access employees,"

he says.

Here are some ways the calls are helpful:

- **At times, the payer's member services department tells the patient one thing, and the provider services department tells the hospital something different.**

"This conflict can skillfully be unraveled by listening to past recordings with the insurance company and conveying the missing information to the patient," says Wemyss. (*For more information about how patient access can use recorded calls to prevent claims denials, see "Payer might claim 'You never sent it!' but patient access can prove otherwise," Hospital Access Management, February 2015, p. 17.*)

- **Occasionally, a patient or family member complains about the lack of professionalism of a patient access employee.**

"In this instance, recordings can paint a very different picture," says Wemyss. "Anytime we receive a complaint of this nature, we immediately research the account notes and listen to the recording."

Even if the audit findings reveal a contrary opinion to that of the complainant, patient access managers thank the patient for the opportunity to review the concern.

"Our scripting outlines how to escalate a call if the patient's frustration level increases," says Wemyss. He always reminds employees that they never truly know what someone is going through on the other end of the phone, because many communication cues are delivered visually.

"We may not pick up on all of the subtleties of the situation," he says. "This is why it is paramount to treat every individual with respect, even when we are not receiving it in return."

SOURCES

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- Alexander Wemyss, MBA, CHAA, Customer Service, Sarasota (FL) Memorial Hospital. Phone: (941) 917-3355. Email: Alexander-Wemyss@smh.com. ■

Thousands of recorded calls provide good QI data

At Sarasota (FL) Memorial Hospital, all inbound and outbound calls are recorded for pre-arrival services, registration areas, and patient financial services.

"We need to record *all* of our calls, to provide us with the best sample size for our data analysis," says **Alexander Wemyss**, MBA, CHAA, supervisor of customer service.

As part of an ongoing quality improvement (QI) initiative, patient access leaders review and score a random sampling of the thousands of calls that are recorded each day. "The recorded calls help de-escalate patient concerns, correct

miskeyed demographic or payment information, and monitor employee performance through scorecard benchmarking," says Wemyss.

Personalized scorecards, developed with The White Stone Group in Knoxville, TN, are used to perform the monthly audits.

"The scorecards allow us to

quantify qualitative factors, in an effort to track the trending and statistical significance of our results," says Wemyss. The same number of recordings are randomly retrieved and reviewed for each employee. This process ensures an adequate sample size is obtained.

"If there is a particular

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conversation that is called into question by a patient, the departmental leadership team will convene to review the recording,” says Wemyss. “This is done through an audit process that is maintained outside of the QI initiatives.”

Supervisors and managers are responsible for reviewing calls; however, employees can and do listen to their own recordings throughout the day. If an employee entered an incorrect insurance policy number, for example, he or she can listen to the call and correct it. “The audio and transcript can also be exported, if the information is needed to assist in an investigation,” says Wemyss.

At Mission Hospital in Asheville, NC, patient access managers listen to 10-15 calls for each scheduler

every month. Patient access managers listen for these things:

- that all the required information was obtained from the patient;
- that the right procedure was scheduled according to what the provider’s office requested;
- that any preparation guidelines associated with the procedure are read back to the patient;
- that the scheduler used a pleasant tone of voice.

Lee Anna Mull, manager of patient access, says that if the call reveals that the employee was argumentative, rude, or dismissive, “we play the call back for the scheduler and discuss how it could have been dealt with differently. If it doesn’t get better, we take corrective action.” ■

Survey of impact from first year of ACA enrollment

The number of Americans reporting they did not receive needed healthcare because of its cost dropped for the first time since 2003, from 80 million in 2012 to 66 million, according to the just-released 2014 Biennial Health Insurance Survey from The Commonwealth Fund in New York City. Also, the number saying they had trouble paying their medical bills or were paying off medical debt fell from 75 million in 2012 to 64 million, which is the first time it declined since this question was initially asked in 2005.

The survey, discussed in the new brief, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect*, was fielded between July and December 2014. It asked respondents about their health insurance status, access to health care, and medical bill

problems and debt over the previous 12 months. (*To access the brief, go to <http://bit.ly/1Csk9Ai>.*)

The survey found improvements on nearly every measure, including the percentages of adults who reported that, because of the cost, they:

- did not visit a doctor or clinic when they had a medical problem, which fell from 29% in 2012 to 23% in 2014;
- did not fill a prescription, which fell from 27% to 19%;
- skipped a recommended test, treatment, or follow-up visit, which declined from 27% to 19%;
- did not see a specialist, which dropped from 20% to 13%.

In addition, the share of adults who said they had trouble paying their medical bills, or could not pay them at all, fell from 30% in 2012 to 23% in 2014. ■

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