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MAY 2015 Vol. 34, No. 5; pp. 49-60

INSIDE

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Emergency department collections nearly double with price estimates

'Making the ask' results in 10% increase

Emergency department (ED) registrars at Davenport, IA-based Genesis Health System's five hospitals collected $190,000 in Fiscal Year 2014. Collections topped $368,000 the following year, after a payment estimating tool was implemented.

Previously, patient access didn't give estimates at all. "We were just collecting copays. If patients did not have copays, we were asking for $100 deposits," says registration supervisor **Alissa Munson**. The tool is the Patient Payment Estimator from Passport Health in Franklin, TN.

ED collections increased 10% last year at Cooper Health System in Camden, NJ, with the simplest of changes: Staff ask for payment consistently. **Pamela Konowall**, assistant director of health care access, says, "After being trained in how to make 'the ask' for each and every visit, employees were amazed at the simplicity of the process."

"... EMPLOYEES WERE AMAZED AT THE SIMPLICITY OF THE PROCESS." — PAMELA KONOWALL, COOPER HEALTH SYSTEM

At University of Pittsburgh Medical Center (UPMC), collections are tracked by individual staff members. "This allows us to work with low performers to coach them," says **Jackie Shaw**, regional director of patient access at UPMC.

Patient access mandates frequent training on collections, based on real-world scenarios, to allow staff members to become comfortable with the process of asking for payment. "We engage staff in every aspect of payment collections by sharing personalized metrics on a daily, weekly, and monthly basis, and recognizing year-to-year performance," says Shaw. More than half of UPMC facilities are averaging a 46% or greater collection rate for total copayments.

Initially, many of Cooper Health's registrars were reluctant collectors. "In short, they were hesitant to ask,"

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management™,
ISSN 1079-0365, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Access Management
P.O. Box 550669
Atlanta, GA 30355.

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SUBSCRIPTION PRICES:
Print: 1 year (12 issues): $429. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $379
Outside U.S., add $30 per year, total prepaid in U.S. funds

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Back issues: $80. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

EDITOR: Stacey Kusterbeck.
EXECUTIVE EDITOR: Joy Daugherty Dickinson
EDITORIAL DIRECTOR: Lee Landenberger

EDITORIAL QUESTIONS
For questions or comments, call Joy Dickinson at (404) 262-5410.

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says Konowall. First, patient access leaders re-trained all registration staff in insurance eligibility and patient liability. "The training department tested employees on their interpretation of eligibility responses and identifying the amount of the copay due for the day's visit," she explains.

Next, patient access trainers created an online module. This module covers scripting on how to ask for a copay, how to explain what a copay means, what the benefits are for paying a copay at the time of service, and how to respond to questions patients might ask. *(See scripting used by patient access staff in this issue.)* "If a patient can't pay the full copay amount, we encourage the patient to make a partial payment," adds Konowall.

Instead of asking patients *if* they wanted to pay their copay, staff ask *how* they will make the payment, by cash, check, or credit card. Payment software also was implemented. "As an additional enhancement to increase cash collection in 2015, credit card swipes were added to the registrars' desktops and 'workshops on wheels,'" known as WOWs, says Konowall.

Previously, employees had to go to a stationary computer or enter the credit card information manually. Adding the swipes eliminated the risk of typing a credit card number inaccurately. "Staff is now comfortable with identifying copays, asking patients for payment, and processing the payment," Konowall reports.

More out-of-pocket

At UPMC, "collections in the ED have always been a challenge," says Shaw. "We continue to improve, even as copays continue to increase." Rising copay amounts are placing a greater financial responsibility on the patient. "Those amounts can be a hardship for patients," says Shaw. If patients express an inability to pay, UPMC's patient access staff members do the following:

- determine if the patients have a flexible spending account or health reimbursement account to help with the costs;
- document reasons given for patients being unprepared to pay;
- ask for a partial payment if the patients say they can't pay the full balance;
- refer the patients to a financial counselor to discuss additional options for assistance.

It often is difficult to provide accurate estimates for patients in

EXECUTIVE SUMMARY

Rising deductibles and lack of information on out-of-pocket costs make emergency department collections difficult, but patient access departments are succeeding with tools and training. Collections at Genesis Health System nearly doubled with a payment estimate tool, and collections rose by 10% at Cooper Health System because staff ask consistently.

- Require registrars to ask for payment at every visit.
- Set the expectation for clinical staff to direct patients to the checkout area.
- Offer a prompt pay discount to patients who pay in full that day.

the ED setting, notes **Patty Devlin**, UPMC's director of self-pay. UPMC's patient access staff members collect outstanding balances on prior accounts from ED patients. However, they don't collect deductibles or coinsurance for the ED visit.

"We may know the deductible is $5,000, but we don't know how much of it is met," says Devlin. "That information is not readily available in the ED."

Genesis Health System's patient access leaders created templates for each of the five acuity levels used in its EDs. "Based on those templates, and information provided by the patient's insurance companies, we are able to provide an estimated amount due for that visit," says Munson.

Patient access staff at Genesis offer an upfront prompt pay discount if patients agree to pay in full that day. Patients receive a 10% discount, and self-pay patients receive a 40% discount. "Offering the discounts has been a great tool to get those who would generally wait to pay to, instead, pay upfront," says Munson. For fiscal year 2015, the department gave patients more than $180,000 in discounts.

Registrars also offer payroll deductions to hospital employees and their families. "Staff that are seen in the EDs really like having the option to make payments over a period of time instead of paying the full amount upfront," says Munson. *(See related story on bedside collection versus collecting at patient discharge in this issue.)* ■

Use scripting to collect ED copays

Emergency department registrars use this scripting to collect copays at the Cooper Health System in Camden, NJ:

"According to your insurance benefit, you will be responsible for ($) co-payment. Cooper accepts cash, credit card, checks, or money orders. How would you like to make this payment today? Thank you for making your payment today, and thank you for choosing Cooper!"

• If the patient states they are not able to pay the full amount: Encourage the patient to make a partial payment, reiterating that cash, credit card, checks, or money orders will be accepted.

• If the patients state they do not have any cash to make payment: Inform the patients that Cooper will accept a payment in the form of credit card, debit card (if applicable), check, or money order.

• If the patients question having to make a payment and state that they haven't had to pay in the past: "There is a possibility that you may not have been required to make a payment in the past. However, your active benefit plan requires a payment of ($) at the time of service. How would you like to make this payment today?" ■

Collect in ED before or after discharge? Both methods have their challenges

Patients likely to leave without financial discussion

The most daunting challenge of collecting in the emergency department (ED) setting involves the simple fact that ill, injured, and tired patients just want to go home, as opposed to having a discussion about how much money they owe.

"Often, it's all about logistics and routing the patient to a checkout desk when the patient is exiting," says **Jackie Shaw**, regional director of patient access at University of Pittsburgh Medical Center (UPMC). Some patients already waited hours to see a physician. For many, the last thing they want is another stop on their way out the door. "We encouraged clinicians to direct patients to the checkout desk upon discharge," says Shaw. "We shared our goals with them and pulled them in as part of the team."

At the point of discharge, patient access staff validate the patient's parking ticket, which saves them up to $25 in fees. **Patty Devlin**, UPMC's director of self-pay, says, "That goodwill gesture has really gone a long way."

If patient access staff collect *before* discharge, they need to do so only after the medical screening examination (MSE) is completed, as required by the Emergency Medical Treatment and Labor Act (EMTALA).

"We encourage the staff to collect at the bedside once the physician sees the patient and the MSE has been completed," says Shaw. "We have the technology to support bedside collection." Registrars monitor a tracking tool, which alerts them that the MSE has been completed.

A much larger percentage of

collections occurs at the point of discharge, however. "Registration completion and accuracy is critical, so collecting at the bedside is a challenge for a busy department," explains Shaw. "We are always looking to increase that percentage. It's a continual area of focus."

At the Cooper Health System in Camden, NJ, copays are collected after triage at the time of registration. If a patient is assigned a room, registration and copay collection are done at the bedside. All patients have an MSE completed before registration. **Pamela Konowall**, assistant director of health care access, says, "If registration takes place before a patient is assigned a room, the patient is registered using a desktop computer."

At Davenport, IA-based Genesis Health System, all attempts to collect occur at the end of the ED visit.

"We have a designated checkout office at our three main campuses," says **Alissa Munson**, registration supervisor. "Clinical staff escort the patients to that office, so that the registration process can be completed." Staff then have the collections conversation with the patient.

Initially, clinical staff members were resistant to this process. "Nurses felt their job was completed once they discharged the patient and the patient left the examination room," says Munson. Patient access leaders met with clinical leaders to set this new expectation. "As with every new process, it took time and persistence to get the process hardwired with the clinical staff," says Munson.

Patient access leaders provided clinical staff with this suggested scripting: "Please stop at the checkout office. Registration will complete your discharge and get you on your way," or "Please have a seat here (pointing to a small waiting area outside checkout). Registration will be right with you to finish your discharge."

When ED collections first started, patient access staff members went into the patient's room right after the MSE was completed. "The doctors alerted us when they felt they had met EMTALA," says Munson.

However, after a few months of this process, hospital leaders decided they did not want the patient's room to be associated with the collections process.

"So we moved that part of registration to the end of the visit," says Munson. "We built checkout offices to accommodate the new process." ■

$4.8 million gained in self-pay revenue: Identify patients' 'hidden' coverage

At another health system, 95% of admitted self-paying patients obtain coverage

If a patient clearly states that he or she has no health coverage, it might seem a waste of time to run a thorough insurance eligibility check. However, registrars at Unity Point Health System — Rock Island (IL) do this check for every self-pay patient, with surprising results.

"We often find they *do* have some kind of insurance," explains **Linaka Kain**, manager of the Marketplace Exchange/disability examiner. "We've had patients who've had coverage for years and don't even know that they've had it." This insurance eligibility check is one reason for a dramatic increase in revenue achieved by the department. "We were able to increase revenue for our self-pay population by $4.8 million" in one year, reports Kain.

Some patients mistakenly discard important insurance information. "We get that all time," says Kain. "They see something from [the Department of Human Services] or the hospital, think it's a bill, and just throw it away. Little do they know that it's an insurance card."

A small group of patients wrongly assume they will get free care if they deny having coverage.

"What they don't realize is that we are going to find out anyway," says Kain. "Before the [Affordable Care Act], many people got their bills written off if they met criteria for charity care. It's not that way anymore."

Charity assistance is primarily for the indigent population and is the "payer of last resort," underscores Kain.

"Everybody has guidelines to follow. Most of the people who were on it are eligible for coverage now."

Many qualify for coverage

At University of California — Los Angeles (UCLA) Health System, about 95% of self-pay patients qualify for Medi-Cal (California's Medicaid program).

"When self-pay patients present, we first try to secure a deposit; then we do a high-level financial screening," says **Helen Contreraz**, director of patient access. "Right now, we are focusing on our inpatient population because the dollar amount

is much higher."

Some patients purchased coverage on the Health Insurance Marketplace but stopped paying their premiums because they lost their jobs. These patients often are surprised to learn they qualify for Medi-Cal coverage. **Cris De Castro**, CCS, manager of financial counseling for patient access services, says, "We make sure they have coverage from the last day their Exchange plan was active."

UCLA Health System's patient access department began offering financing to patients in December 2014 by arranging a loan on favorable terms for patients with a third-party bank. Contreraz says, "Deductibles are quite high. Many patients need a year or 18 months to pay them off."

"Bronze" plans purchased on the Health Insurance Marketplace in 2015 have an average deductible of $5,181 for individuals, up from $5,081 in 2014, according to a report from HealthPocket, which publishes health insurance market analyses.

Patient access determines if the patients qualify for a loan based on their credit score and ability to pay. Castro says, "We've been successful in getting people prequalified for loans to pay off high deductibles, at terms that the patients need." *(See related stories in this issue on building a trusting relationship with patients and success with presumptive eligibility.)* ■

EXECUTIVE SUMMARY

Patient access leaders at Unity Point Health System — Rock Island increased revenue by $4.8 million by identifying current coverage and obtaining Medicaid coverage for self-pay patients. Some patients deny having coverage in a misguided attempt to obtain charity assistance. Others are unaware of existing coverage. Patient access can do the following:

- alert providers' offices if patients are uninsured;
- ensure post-surgical patients have coverage for prescriptions and follow-up care;
- reschedule elective procedures until patients obtain coverage.

It's not just about money: Build trusting relationship

Show self-pays you're there to offer help

Initially, many self-pay patients have a negative perception of financial counselors.

"By easing their financial burden, we gain their trust," says **Cris De Castro**, CCS, manager of financial counseling for patient access services at University of California — Los Angeles Health System. "Patients see we are there to help them, not just to get them to pay such-and-such amount."

Unity Point Health System — Rock Island (IL)'s Medicaid specialists and financial advocates recently took on the role of educating self-pay patients presenting at the health system's 31 clinics and four Express Care Centers.

"That has been a big undertaking," says **Linaka Kain**, manager of the Marketplace Exchange/disability examiner. "Previously, no one was counseling these patients. We started having them refer the patients directly to us."

This change means that no self-pay patient falls through the cracks. "Sometimes at the hospital level, we forget about the clinic," says Kain. "The patient will end up either in the clinic, the ED, or the hospital. It's a circle, so why not close that gap?"

Financial advocates at Unity Point Health System — Rock Island tell newly insured patients how to use their coverage, how to establish a primary care provider, and how to use the emergency department (ED) appropriately.

"It's not an easy process," says Kain. However, the department already is seeing results: far fewer calls than the previous year. "Last year, we had so many people call us on the phone asking questions. We don't have that this year," says Kain. "The people we helped with enrollment are already educated."

Medicaid specialists and financial advocates make a point of telling every newly enrolled patient awaiting insurance coverage, "Now we have assisted you in applying for insurance. It takes anywhere from 30 to 45 days to get a decision. But if you find yourself feeling poorly and in need of medical attention, go to the closest ED and seek care. Don't think that you have to wait until you get your insurance decision. Your welfare and safety comes first!"

"We don't want something catastrophic to happen because they think nobody will take care of them," says Kain.

In cases in which a patient is in a pending status for Medicaid and ends up not qualifying, but has an unexpected ED visit during that time, the hospital then would apply for charity assistance.

"We had one instance where the patient was having a heart attack and went to the ED," says Kain. "Having somebody tell them, 'If you need it, go to the ED,' could have saved their life." ■

Presumptive eligibility is big revenue producer

Immediate coverage is 'godsend' for patients

Patient access staff at Unity Point Health System — Rock Island (IL) occasionally see patients who reside in Iowa. There is a marked difference in how self-pays are handled in the two states. The reason is that Iowa offers a larger eligibility criteria for presumptive eligibility, which "has been a big revenue producer and a godsend for a lot of patients," says **Linaka Kain**, manager of the Marketplace Exchange and disability examiner.

Under the Iowa presumptive eligibility program, eligible patients are given a Recipient Identification Number right away, so their care is not delayed. "If we have somebody scheduled for surgery a week from now, it usually takes about 48 hours to show up in the online verification system," says Kain. "But by the time of surgery, they've got the coverage."

Since Illinois has not yet passed pending legislation allowing full presumptive eligibility, the process of obtaining coverage for self-pay patients is more difficult. After patients apply for Medicaid, says Kain, "it can be anywhere from a 30- to 45-day turnaround, compared to presumptive eligibility where you have an answer within 24 hours."

This delay presents a problem for critically ill intensive care unit patients awaiting transfer. "That is very difficult to do if they don't have a presumptively approved ID number," says Kain. "If somebody is presumptively eligible, we have a lot easier time transferring them to another facility."

Approval in minutes

At University of California — Los Angeles Medical Center, presumptive eligibility "helps us to at least bridge the patient onto something else for 60 days," says **Cris De Castro**, CCS, manager of financial counseling for patient access services.

Previously, anyone between ages 21 and 64 completed a regular Medicaid application. This application took from three to eight months to approve. "Now we can get them approval in five minutes if they meet the criteria," says Castro. "That helps the hospital tremendously."

Financial counselors emphasize the need for patients to submit the necessary paperwork, in order to not lose coverage. "We don't want them to wait until the sixtieth day to submit all the documentation requirements, so there won't be any gap in their coverage," says Castro. "For the most part, we've been successful in that."

Presumptive eligibility helps with discharge planning for admitted patients, because outpatient care and prescriptions are covered. "That benefits everybody all around," says Castro.

Patients find it easier to obtain follow-up care in other settings, post-discharge. "If the patient has only a pending case number, a lot of places want to know that they have full scope coverage, so they know it's not restricted," explains Castro.

On the hospital side, says Castro, "we can bill Medi-Cal right away. Previously, we were billing patients, and if the patient couldn't pay, then it went to bad debt." ■

Department reaches million-dollar milestone

Staff morale is high during 'tough time of change'

In January 2015, patient access employees at Mercy Hospital Springfield (MO) collected more than a million dollars in one month for the first time. This milestone didn't go unnoticed by anyone in the department.

"Management celebrated the success of its team by serving root beer floats. Each coworker was presented with a card and a movie ticket to a local theater, provided with donated funds," says financial analyst **Vera Hart**.

One of the biggest challenges is balancing increased point-of-service collections with providing compassionate care, according to

Jeff Brossard, CHAM, director of patient access. "It is so very important to celebrate our successes," Brossard emphasizes. "We all respond better to positive reinforcement than negative reinforcement."

The million-dollar milestone was especially noteworthy because patient access only recently began collecting from patients routinely. Many were uncomfortable asking patients for money, in part due to the hospital's nonprofit status.

At first, many patients challenged patient access employees by stating, "We have never been asked for money in the past," or "Do I have to pay to be seen?" "Patient access had to learn to ask for payment without offending the patient or giving the impression that the patient had to pay or wouldn't be seen," says Hart.

The hospital has long been known in the community for willingness to meet the needs of those who are not able to pay. "Patient access representatives suddenly had to be more intentional with their request for money," says Hart.

Goals slowly increased

Collection goals slowly were increased, to bring the hospital closer to the Healthcare Financial Management Association benchmark of 2% of net revenue.

"Often when working with individualized goals, it can be perceived as negative reinforcement," says Brossard. "Any chance we get to celebrate our successes helps to change that perception to more of a positive reinforcement."

Each team member was given a personal goal based on the total goal for patient access, the goal for their specific department, and their job within that department.

"Coworkers are praised and recognized for their hard work and high standards," says Hart. "This helps maintain a high morale even through this tough time of change."

Point-of-service collections increased from a monthly average of $241,824 in fiscal year 2011 to $310,653 in fiscal year 2012 and $594,574 in fiscal year 2013. "There has been a continued push to improve collections," says Hart.

In fiscal year 2014, monthly collections averaged $802,000, which is a 332% increase over a three-year period. In the first seven months of fiscal year 2015, monthly collections were $106,000 higher on average.

Celebrating successes

Here are some ways the department continues to celebrate successes with point-of-service collections:

• Successful collectors earn points in the hospital's Going the Extra Mile (GEM) program.

Employees earn points for compliments given to them via comment cards, overheard comments, or recommendations from coworkers or supervisors. Based on the number of points received, the employee receives a plastic "gem" attached to a lapel pin to wear on their clothing or on a plastic badge.

"When employees move to the next level, they are given a certificate and a new 'gem' to wear," says Hart. "Employees are recognized for their GEMs at our quarterly meeting." These levels are used:

— 1 GEM: The employee receives a citrine gem and a plastic badge.

— 10 GEMs: The employee receives an amethyst gem and five "Mercy points," which can be redeemed in the hospital gift shop. One Mercy point equals $1.

— 25 GEMs: The employee receives an aquamarine gem and 10 Mercy points.

— 50 GEMs: The employee receives an emerald gem and 25 Mercy points.

— 75 GEMs: The employee receives a ruby gem and 50 Mercy points.

— 100 GEMs: The employee receives a diamond gem, 100 Mercy points, and a special plaque signed by the patient access director and the vice president of finance.

"We periodically award coworkers with a GEM for top collector or most improved collections," says Brossard.

• The department enjoys meals together.

Some of the food and supplies come from donations or gift cards that are used to pay for a catered entrée.

"Our management team contacts supermarkets and specialty stores to see if they are willing to help with specific items," says Hart. "The cost to

EXECUTIVE SUMMARY

Monthly point-of-service collections topped $1 million for the first time at Mercy Hospital Springfield. The department made a point of celebrating successes to motivate reluctant collectors.

- Managers gave each employee a movie ticket and served root beer floats.
- Each team member was given a personal goal.
- Staff members enjoy meals together, with food and supplies donated or brought in by managers.

the department has been near zero."

Patient access managers and supervisors bring vegetables, salads, and desserts, and serve the meal in a large conference room. "This year, we opened this up for anyone to bring something," says Hart. "The management hangs out to visit with coworkers." The meals are scheduled during a time which covers all the day shifts, but the night shifts aren't overlooked. "Management returns and sets up again in the evening for the overnight coworkers in the ER," says Hart. ■

Look outside your department to move up quickly in patient access

Entry-level role is good foundation for advancement

Patient access employees at Riverside Regional Health System in Newport News, VA, are promoted based on a new tier system implemented in December 2014.

"We re-evaluated all employees and placed them in the new tier, based on the required criteria," says **Robin Woodward**, CHAM, system director of patient access.

All employees in patient access, customer service, patient accounting, scheduling, insurance verification, and healthcare information and management systems were categorized in one of three tiers based on experience, education, and certifications. *(See tiers used by the department for patient access and customer service positions included in this issue.)*

Patient accounting, the Call Center, and insurance verification are revenue cycle departments, but these are separate from patient access. "Those areas may have tiers higher than patient access," notes Woodward. Many employees received a pay increase because of this difference.

All employees had their years of service, experience, and certifications verified to determine which tier they fell into. "Once complete, all employees were moved to their applicable tiers at once," says Woodward.

Before the tiers were implemented, patient access leaders gave a presentation to each department about updated job descriptions and required criteria.

"Over the course of several days, management met with individuals to update them about their new level and/or pay, with effective dates," says Woodward. Most employees received a pay increase. "However, if experience, years, and/or education did not allow for any increase, they stayed at Tier 1, and the pay did not change," says Woodward.

Customer service experience, working at a call center, and medical office duties that include scheduling and knowledge of insurance terms are some of the criteria staff members must meet to be promoted. *(See related story on promotions within the revenue cycle in this issue.)*

"Medical coding and accounting is a plus for job placement in revenue cycle departments," adds Woodward. "We have broadened our scope of what is an accepted revenue cycle background."

Go outside work area

Education doesn't always mean going to school and earning another degree. **April C. Robinson**, MBA, MHA, former patient access manager at Palmetto Health Richland in Columbia, SC, says, "It can simply mean staying abreast of the changing culture and the fluid environment that you work in." She recommends patient access employees do these things to advance:

• Increase familiarity with systems used by patient access.

Many patient access areas use multiple systems for registration, scheduling, electronic medical records, and billing. "Being educated on how these fragmented systems work with one another gives employees the ability to function from the front end of the revenue cycle to the back end," says Robinson.

• Research similar facilities.

EXECUTIVE SUMMARY

Patient access employees need in-depth familiarity with systems, customer service skills, and comprehensive knowledge of the revenue cycle to advance, according to revenue cycle leaders. Employees can:

- apply for available revenue cycle jobs outside their departments;
- ask to cover shifts in other areas;
- take courses in public speaking and communications.

"This is a great way to expand your knowledge and learn best practices," says Robinson. One way an entry-level employee can learn about other facilities is to join a state or local professional group for patient access. Robinson is a member of her state's National Association of Healthcare Access Management chapter, the South Carolina Association of Healthcare Access Management, which offers annual workshops and conferences.

"These meetings allow time for the participants to get together and discuss current hot topics and common concerns within access service departments," says Robinson. "It is a great networking opportunity."

• **Take community college courses in Microsoft Office, public speaking, basic medical terminology, English composition, and general communications.**

"These basic classes can help build the foundation that can lead to promising careers," says Robinson. Some organizations offer tuition reimbursement for such courses. If this reimbursement is not the case, she says, "building an educational foundation for a better future always pays off in the long run." ■

Encourage staff to move within revenue cycle

Patient access employees are alerted to any openings within the entire revenue cycle at Riverside Regional Health System in Newport News, VA. Managers actively encourage them to apply for higher-tier jobs that become available.

"We want to promote from within. We encourage career paths within our divisions," says **Robin Woodward**, CHAM, system director of patient access. Each division that has openings sends a group email to members of the management team, who make their direct reports aware of upcoming postings.

"Several employees started in registration and now manage other revenue cycle departments," says Woodward. One emergency department registrar moved to inpatient and ambulatory registration, then into a patient access analyst role. "That employee had a wealth of knowledge working with many hospital units and other departments for account reviews," says Woodward. "The employee is now a supervisor."

An entry-level patient access role gives employees a good foundation to move to other revenue cycle areas. "The understanding of systems, and how information starts with patient access and flows downstream, gives them an advantage," Woodward explains.

Go outside of your area

If you work in a large patient access department, ask to cover different locations or different shifts, suggests **April C. Robinson**, MBA, MHA, former patient access manager at Palmetto Health Richland in Columbia, SC.

This request can be an opportunity for advancement. "Learn how other areas function," says Robinson. For example, if your facility consists of multiple buildings and locations, such as a children's hospital, heart hospital, or outpatient physician practices, request time to "job shadow" in these other locations.

"Work not only with the access services teams in these areas, but with the clinical staff as well," advises Robinson. "Each location functions differently because they serve very different patient populations."

The goal is to watch the patient flow and processes from start to finish. "Understand how everyone's role impacts not only the revenue cycle, but the overall patient experience," says Robinson. ■

This education is now 'must-have' for access reps

Below is a list of the six educational requirements used in revenue cycle areas at the Riverside Health System based in Newport News, VA:

• **Patient Access Rep I.** High school diploma or passing the General Educational Development Test (GED) required and one or more years of experience in business office setting preferred. College degree accepted in lieu of experience. Certified healthcare access associate (CHAA), issued by the National Association of Healthcare Access Management, obtained within two years of employment.

• **Patient Access Rep II.** High school diploma required and 3 plus years of healthcare-related experience or college degree and one or more years of medical office/billing/ insurance experience. Master's degree can count for one year of additional experience. CHAA-certified.

• **Patient Access Rep III.** High school diploma required and five or more years of revenue cycle/ insurance/ medical office experience and/or college degree with two

or more years of revenue cycle/insurance/medical office experience. Master's degree can count for one year of additional experience. CHAA-certified.

• **Customer Service Rep I:** High school diploma or GED and two or more years of experience in revenue cycle/business office setting or college degree plus one year customer service experience. Master's degree can count for one year of additional experience. Revenue cycle-specific certification required: CHAA or certified patient account technician (CPAT), issued by the American Association of Healthcare Administrative Management, within one year required.

• **Customer Service Rep II:** High school diploma or GED and three plus years of experience in revenue cycle, business office setting, or college degree; two plus years of customer service experience required. Master's degree can count for one year of additional experience. Can substitute demonstration of strong proficiency as a Customer Service Rep I in lieu of experience. Revenue cycle-specific certification required: CHAA or CPAT.

• **Senior Customer Service Rep:** High school diploma or GED and five plus years of experience in revenue cycle/business office setting or college degree; and three plus years of customer service experience required. Master's degree can count for one year of additional experience. Can substitute demonstration of strong proficiency as a Customer Service Rep II in lieu of experience. Revenue cycle-specific certification required: CHAA or CPAT. ■

Access leaders: Telecommuters are *more* productive

Patient access managers might envision employees working from home getting very little done due to ringing doorbells, kids playing, or housework getting in the way of work.

"There is concern over the productivity of the employee if they can't visually see them," explains **Darlene Powell,** CHAA, CHAM, patient access manager at Bronson Methodist Hospital and Bronson Lakeview Hospitals in Kalamazoo, MI.

However, Powell, who has two telecommuting employees, has found the opposite to be true. "My at-home staff tend to produce more due to less distractions; they don't have the same interruptions as their in-house co-workers," she says. "They tend to have higher productivity for that reason."

Powell tracks productivity of telecommuters the same way she does for onsite staff members. "The staff are included in the same reports as our in-house employees," she explains. "We can see daily activity for registrations, calls, and work queues."

At Geisinger Health System in Danville, PA, remote patient access workers "are evaluated on results," says **Mark S. Rodi**, MHA, CHAM, associate vice president of revenue management and access.

"To participate in the program, you must be considered the 'best of the best.'"

An agent scorecard is used to track daily, weekly, and monthly performance in key measures such as calls per hour, talk time, and scheduled appointments. "Performance expectations are used for the recruitment and continued participation in the remote workforce program," adds Rodi.

Real-time call activity can be monitored for all employees, including remote staff members, using software on managers' desktops. "Supervisors are able to monitor live or recorded calls to offer coaching to agents," says Rodi.

"Very limited space" was a primary reason that patient access areas at Oregon Health & Science University Hospital in Portland first considered telecommuting.

"Freeing up a couple of workstations allowed us to move forward with hiring a couple of additional staff to cover an increased workload," says **Desember Brucker**, patient financial services manager. Two employees telecommute, but the department is looking to increase that number.

"Employees were very excited about the opportunity to work from home and lack of commuting costs," Brucker says. The organization pays for the telephone line, telephone, and computer equipment. The employee pays for the Internet connection. "However, depending on the number

EXECUTIVE SUMMARY

Allowing employees to work from home frees up space in the department, increases productivity, and improves morale, according to patient access leaders.

- Remote staff provide coverage during inclement weather and phone outages.
- Employees save money on commuting, clothing, and meals.
- Face-to-face meetings connect telecommuters to colleagues.

of employees who telecommute, there is cost savings in reduced rent and overhead," says Brucker.

Powell says telecommuters save her departments money because at-home workers agreed to take a pay cut, since they no longer perform tasks such as insurance verification. "Due to the fact that this process takes staff off the phones for extended periods of time, we selected a core group of staff that rotate this function," she explains. "The at-home staff weren't part of that rotation and do only minimal verification." At-home staff obtain the patient's insurance information and notify the provider's office if a test requires an authorization. "Then the authorization process is done by the core staff assigned to that function," says Powell. "We changed their job description to differ from those that work in-house, because of different job responsibilities."

The centralized scheduling department at Geisinger Health System freed up much-needed office space by allowing 24 agents, who comprise 18% of the department, to work remotely. Employees are happy to save money on commuting, clothing, and meal costs.

"We also have the remote staff readily available to offer phone coverage during days of inclement weather and power or phone outages," reports Rodi. *(See related story in this issue on common concerns involving telecommutings.)* ■

Leaders: Telecommuting worries largely unfounded

"Fear of the unknown" makes some patient access leaders hesitant to allow staff to work from home, says **Darlene Powell**, CHAA, CHAM, patient access manager at Bronson Methodist Hospital and Bronson Lakeview Hospital in Kalamazoo, MI. Here are some common concerns about telecommuting for patient access areas:

• Managers want to maintain the same level of customer service as is expected onsite.

"This was one of my initial discomforts regarding allowing employees to work from home," says **Desember Brucker**, patient financial services manager at Oregon Health & Science University Hospital (OHSU) in Portland.

To address this concern, managers require telecommuting employees to undergo an initial inspection of their work space, with privacy a main concern. Care providers are required for children under 12 during work hours, paid for by the employee. "We have a continued right to inspect the work area at times throughout the year," adds Brucker.

At Geisinger Health System in Danville, PA, patient access supervisors conduct home visits with their remote staff to ensure compliance with these requirements of the remote workforce policy:

— The designated work area must be separate from the active living area of the home.

"The workspace should be comfortable, conducive to concentration, and allow for mental and physical separation from family during work hours," says **Mark S. Rodi**, MHA, CHAM, associate vice president of revenue management and access.

— Appropriate arrangements should be made as necessary to provide caregiving to family members.

— There must be proper lighting.

— There must be a fire alarm and smoke detector in the room designated as the work area.

— There must be a proper electrical source.

— There must be an approved ergonomic workstation.

Powell ensures that the employee's work area is private and can be locked to protect confidentiality of patient information.

"I haven't identified any issues with regard to the home visits," says Powell. "The staff actually like to show off their office areas and welcome me to stop by anytime."

• Managers are concerned about employees staying up to date on policies and procedures.

"Over time, we have not found this to be as large of a concern as initially feared," Brucker says. Telecommuters attend staff meetings and training sessions in person. They also receive continual updates through email and instant messaging.

• Trouble-shooting computer issues is more challenging for at-home workers.

A reliable, fast Internet connection is a must, says Brucker. "This is one

COMING IN FUTURE MONTHS

- Add customer service to patient access job descriptions
- Easy ways to improve morale of weekend and night registrars
- Find out what staff *really* think of patient access leaders
- Revamp outdated processes for estimating out-of-pocket costs

issue that we came across early on in our telecommuting project," she says. One employee who lived on the outskirts of the city found that the speed wasn't as fast as the carrier had said it would be. She eventually switched carriers and has not experienced any problems since.

At times, OHSU's hospital technicians must travel to the employee's home to assist with computer problems. "Our technicians can access employee computers that are on campus, but they do not have the ability to access computers off of campus, unfortunately," says Brucker.

Too-slow Internet connections occasionally hinder productivity of at-home workers at Children's Hospital of Atlanta. "Staff may experience technical issues at home that are not supported by your IS [Information Systems] department," says **Tammy Jones**, manager of hospital authorization and patient access.

• Telecommuting is not possible for all patient access staff.

Not all employees are able to take advantage of a more relaxed dress code, time and cost savings with no commute, and less fuel and lunch expenses. "While identifying roles who are capable of working remotely, it may decrease the morale of others who are not considered," acknowledges Jones.

• There is a need to ensure remote workers adhere to patient privacy regulations.

"Remote and on-site staff only have access to the last four digits of a social security number in our systems," says Rodi. "Remote staff do not collect payments over the phone."

Bronson's telecommuting patient access employees aren't taking payments over the phone. "But we hope to start taking credit card payments for self-pay patients and any copays and deductibles when applicable," says Powell. Each year, employees sign a confidentiality agreement and an employer agreement regarding breeching patient information, including social security numbers obtained by at-home employees.

"I have never experienced any issues with regard to this from my at-home staff," says Powell. "They have many years vested with the hospital and are stellar employees and understand the importance of protecting patient information." During site visits, Powell verifies that at-home employees' offices and file cabinets can be locked. "This space also has to be away from a main living area. Both my staff have a specific room dedicated in their basements," she says.

• Employees who work from home sometimes feel less connected to the department.

Lack of "face time" with their supervisor and peers can affect relationships. Rodi says, "This is one of the biggest challenges associated with a remote workforce."

The patient access leadership team communicates with teleworkers via the phone, email, and instant messages, but also in person. "Regular scheduled face-to-face meetings with supervisors is important. Attendance in departmental meetings are required," says Rodi. "This allows everyone to connect on a personal level."

When communicating with at-home workers, Powell uses the phone when a lengthy conversation is needed, email if she's conveying messages going out to the entire team, and instant messages if a quick response is needed. She also conducts occasional home visits. "I observe them on calls to see how their routine flows," adds Powell. ■

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