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INSIDE

AHC Media

Patient access can give hospital a 'leg up' on the competition

Revamp inconsistent, outdated price estimate processes

Collections increased 19%, which was an additional $3.6 million, in 2014 compared to the previous year, and payment plans increased by 27%, which was an additional $2.8 million in revenue, after patient access leaders at Novant Health in Winston-Salem, NC, began giving price estimate letters to surgical patients prior to service.

"With estimates, we are often able to set up the self-pay patient on a payment plan prior to service, as well as set up the plan to kick off after insurance pays for our insured patients," reports **Craig Pergrem**, MBA, senior director of revenue cycle, pre-service, financial counseling, and onsite access.

Patient access areas at Mary Rutan Hospital in Bellefontaine, OH, expect to move up to 25% of current bad debt to charity after implementing price estimator software. "There may be additional reduction, not just movement, of bad debt, as well," says **David Kelly**, director of revenue cycle.

"WE ARE IN A VERY TUMULTUOUS TIME, GOING FROM MINIMAL PATIENT COSTS TO VERY TRANSPARENT."
— STEVE SCHAEFER, VIRGINIA MASON HEALTH SYSTEM

Patient access departments that provide patients with good estimates give the hospital a distinct competitive advantage in the marketplace, according to **Steve Schaefer,** vice president of finance at Seattle-based Virginia Mason Health System. "The hospital that can deliver around accuracy in out-of-pocket costs is going to have a leg up," he says. "The patient is quickly becoming a consumer. As we all know, whenever we go shopping, we always look at our costs."

Informed decisions needed

Increasing the accuracy of estimates for out-of-pocket costs is a top priority

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for Virginia Mason's patient access leaders.

"In the past, it wasn't a big deal because you just paid a copay. There was really no reason to be transparent," says Schaefer. "We are in a very tumultuous time, going from minimal patient costs to very transparent."

Patient access leaders nationwide are responding to a growing demand to inform patients of costs on the front end. "We in healthcare need to educate and set expectations, so that patients can make healthcare decisions with their eyes wide open," says Schaefer. *(See stories in this issue on Virginia Mason's Patient Cost Estimator service and how incorrect codes result in inaccurate estimates.)*

The trend is largely driven by patients' higher out-of-pocket costs. "We are moving into consumerism," says Schaefer. "Patients are looking at cost, quality, and service as the three pillars that guide their purchasing decisions."

Schaefer points to recent legislative debates surrounding price transparency in healthcare. "Invariably, somebody pounds the table and says, 'I can go to Starbucks and find out what a cup of coffee costs. How come healthcare can't do the same thing?'" he says.

There is no mystery about what goods or services cost in other industries. "When we purchase something in our free enterprise system, we have a one-to-one relationship between price and cost. If it's $1.50 for a soda at a vending machine, we know as a consumer the cost will be $1.50," says Schaefer.

Patients are unprepared when healthcare costs turn out to be far more complex than in the retail world. "In the old days, every once in a while you got a patient with 80/20 coinsurance who unknowingly went out of network and got shocked by a big out-of-pocket expense," says Schaefer. This expense typically was discovered only after the patient received a bill. Today, such unexpected high out-of-pocket costs are commonplace.

"Where else, other than healthcare, would that occur?" asks Schaefer. "It just doesn't happen."

Consistency often lacking

At Mary Rutan Hospital, cost estimates are given only when patients call and request them.

"The calls are usually routed to the operational departments themselves. This yields only partial estimates and a lack of consistent methodology," say Kelly.

The rehabilitation team estimates the patient's total out-of-pocket costs, for example, whereas the cardiology department quotes gross charges.

EXECUTIVE SUMMARY

Patient access departments are revamping cost estimate processes due to patients' growing demand for cost transparency. Collections increased 19% with price estimate letters at Novant Health. Bad debt is expected to decrease by 25% with price estimator software at Mary Rutan Hospital.

- Financial counselors build trusting relationships with patients.
- Managers implement standardized policies for price estimate tools.
- Surgery schedulers obtain correct CPT codes for patient access.

"At present, methods vary between departments. That yields wildly varying estimates," says Kelly.

Surgery estimates often are given by one team, while other procedures are given by a different team. "Currently, our organization has a very disparate, inconsistent process for giving estimates," says Kelly. "We're consolidating the process to one team, so all estimates come from the same source." The department is making these changes:

- Outbound calls will be made to scheduled patients.
- Financial counselors will visit all inpatients.
- Emergency department patients will be given estimates at the point of service.

"There will be large amounts of training necessary for all three methodologies," says Kelly.

"Only an estimate"

When Mary Rutan's financial counselors visit inpatients, they will take the opportunity to explain how the final cost ended up differing from what originally was projected and review the updated estimate.

"We're drafting some of that scripting now," says Kelly. "That verbiage will be printed on every single estimate we hand to a patient."

This new process doesn't prevent the unexpected higher costs from occurring in the first place, however.

"That needs to occur at the leadership level," says Kelly. All involved areas need a better understanding of how slight changes in procedures can result in dramatic cost increases for patients. "There needs to be outreach across silos, from patient access leadership to operational leadership to case management leadership," urges Kelly.

Novant Health's price estimate letter states, "This is an estimate for services that we have at this time," and patient access staff let patients know that the estimate is not an exact science.

"We also record all our calls with our patients and can use that to let them know how often we have told them it is an estimate," says Pergrem. The recordings are used if a patient claims the patient access representative never told them it was an estimate or was unsympathetic to the patient's financial needs. *(For more information, see "Were access staff really as rude as caller claims? Recorded calls will give you an answer,"* HAM*, March 2015, p. 34.)*

"It keeps the representatives on their toes and also protects them from anyone accusing them of something that didn't happen," says Pergrem. "It eliminates the 'he said/she said' process completely."

SOURCES

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- **Steve Schaefer**, VP of Finance, Virginia Mason Health System, Seattle. Email: steve.schaefer@VirginiaMason.org.
- **Craig Pergrem**, MBA, Senior Director, Revenue Cycle, Pre-Service, Financial Counseling and Onsite Access, Novant Health, Winston-Salem, NC. Phone: (336) 277-7249. Email: wcpergrem@novanthealth.org. ■

Posted prices aren't enough: Patients want more sophisticated information on costs

'Total retooling' of the role of members of the patient access department

Seattle-based Virginia Mason Health System recently implemented a Patient Cost Estimator service, available via phone, online, or in person, to anyone inquiring about scheduled or planned inpatient and outpatient medical procedures.

"We produce 50 to 75 estimates daily," reports **Steve Schaefer**, vice president of finance. "We have found these estimates to have a 95% accuracy rate."

While the organization also posts prices of its top 100 most common outpatient surgical procedures, these posts don't necessarily reflect what a particular patient will pay. "That is what drove us to the Cost Estimator," says Schaefer. "Patients want something more sophisticated than just posted prices, which have no relevance to the bulk of consumers shopping."

Over time, Schaefer expects to see increases in front-end cash collection and decreased bad debt as a result of the Patient Cost Estimate service.

"It's all about trust," he says. "As patients see that they can trust this tool and the estimates we are providing, they will be more willing to pay prospectively rather than retrospectively."

Tough financial discussions with patients call for top-notch customer

service skills. "The two most sensitive things in our lives are health and money," says Schaefer. "When those two things come together and converge, it's a very, very difficult conversation."

For this reason, Virginia Mason's financial navigators don't just give information to patients. They do their best to build trusting relationships. "We see this group as a type of sales force. As people shop, they need to talk to someone they can trust," says Schaefer. "Patients want to feel they are being dealt with in a fair, equitable manner, with care and compassion. Those things are critical to purchasing decisions."

Shifting costs to patients not only demands updated processes for price estimates. It also places patient access in an entirely new light within the organization, according to Schaefer. "It is no longer a clerical position," he says. "This will be a total retooling of who you want in that kind of position."

Closer estimates given

At Mary Rutan Hospital in Bellefontaine, OH, patient access managers are creating standardized policies and procedures so all registration areas use the department's price estimate tool consistently.

"We expect to give patients an estimate specific to their plan, their planned procedure, and their current insurance out-of-pocket status," says **David Kelly**, director of revenue cycle.

Patients will be routed to a centralized team who can provide estimates for all services within the organization.

"We'll conduct staff education sessions, including role-play sessions to get team members into the mindset of the patient," says Kelly. Patient access employees will practice these scenarios:

- patients asking about in-network or out-of-network benefits;
- patients asking questions about financial assistance, payment plans, and discounts;
- patients asking questions about how Mary Rutan compares to other facilities.

The price estimate tool at Virginia Mason Health System factors in contractual agreements with payers, eligibility, and procedure codes related to the patient's care, whether the deductible was met, whether the out-of-pocket maximum was met, and whether any copays or coinsurance are due. "Previously, we didn't factor in ancillary, laboratory, or radiology services," notes Schaefer. "We now can get to a very, very close estimate for out-of-pocket." ■

Incorrect CPT codes lead to incorrect estimates and sometimes write-offs

If a procedure ends up being slightly different than it was expected to be when a price estimate was provided to a patient, this difference can cause major problems for patient access, the patient, and the hospital.

"Small changes in care can yield big changes in expense to the patient," says **David Kelly**, director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH. Sometimes a surgical procedure simply takes longer than expected.

To address the problem of incorrect CPT codes, patient access leaders at Novant Health in Winston-Salem, NC, met with leadership in the surgery scheduling department. "They now get the code that the surgeon is authorizing and place it in a field in the system that lets us know what to price," says **Craig Pergrem**, MBA, senior director of revenue cycle, pre-service, financial counseling, and onsite access.

Patient access worked hard to achieve a collaborative relationship with clinical areas to ensure the correct CPT codes are obtained. "An informed patient who knows what to expect ahead of time, whether they pay prior to service or not, is better off by not receiving that surprise bill after their service," says Pergrem.

Failure to obtain correct procedure and diagnosis codes, or the frequency and dosage for infusion or injectable drugs, are two common reasons for incorrect price estimates given to patients at Salt Lake City, UT-based Huntsman Cancer Hospital.

"We end up billing with different codes from the ones we used for estimates," says **Junko I. Fowles**, CHAA, supervisor of patient access and financial counseling. A colonoscopy is sometimes billed as a diagnostic procedure instead of a screening examination. "Therefore, the patient's plan processes the claim differently," says Fowles.

For more than a year, Huntsman Cancer Hospital's patient access areas have used a price estimate tool for all scheduled services, except transplants and cosmetic services. "We have been very successful providing accurate service estimates to our patients," reports Fowles. However, these two factors sometimes lead to incorrect

estimates:

• Incorrect service location and patient status, whether clinic, outpatient, day surgery, observation, inpatient, or emergency department.

In terms of the patient's insurance coverage, "there may be some variation for inpatient or observation services compared to outpatient services," Fowles explains.

• Inaccurate insurance payer and benefits information.

"Our estimates are calculated based on the historical allowed amount data," explains Fowles. "For some plans, the allowed amount is higher than our billed charges. Therefore, coinsurance is miscalculated."

If patients end up being billed much higher than the quoted estimated amount, the case is escalated to direct supervisors and managers for resolution. In this scenario, says Fowles, "each estimate is reviewed case by case. Supervisors or managers may approve additional discounts on the self-pay balance."

SOURCE

- **Junko I. Fowles**, CHAA, Huntsman Cancer Hospital, Salt Lake City, UT. Phone: (801) 587-4036. Email: Junko.fowles@hsc.utah.edu. ■

$500K in revenue expected in first year of financial navigator program

Alternative funding lifts patients' financial burden

A financial navigation program started in August 2014 already has increased revenue by $330,000 at Maury Regional Medical Center in Columbia, TN.

"We are reviewing some very out-of-the-box ways to help fund patient responsibility. We have had tremendous success," reports **Rodney Adams**, director of pre-service and patient access.

Some patients qualify for alternative funding sources, such as assistance from various foundations or pharmaceutical companies. "But the process for enrollment is complex and very laborious," says Adams. "This leaves patients confused, frustrated, and tired, not to mention they are still physically sick."

Patient access leaders started the program to "financially navigate" oncology patients through the nuances of their insurance and identify any possible alternative funding sources. "We dedicated one FTE to financial navigation," says Adams. "We have seen a tremendous impact on our oncology patient population."

Adams expects the financial navigation program will net the hospital $500,000 in its first year. Previously, this amount would have been uncompensated care: bad debt or charity. "We also see our disability assistance program netting over $2 million annually," he says. "And I think there is still more to be recovered."

"Heavy burden" relieved

Patient access is able to financially assist only 10-20% of oncology patients. "But the ones we can help makes everyone smile," says Adams. Patient access employees are gratified to tell patients with limited or no insurance coverage that they have secured alternative funding or obtained approval for Medicaid or a plan on the Health Insurance Marketplace.

"We can literally see the relief of a heavy burden being removed from them," says Adams. "It's those incredible moments that validate to us that we are doing the right thing, not only for our health system, but for our patients."

The program has made the hospital stand out in the community, according to financial navigator **Amanda Holt**. "It's a brilliant solution that benefits the patient, their caregivers, and the hospital, just

EXECUTIVE SUMMARY

Patient access leaders at Maury Regional Medical Center recouped $330,000 in less than a year with a new financial navigator role. The program connects patients with alternative funding sources.

- Patients often report their biggest concerns are financial.
- About 10% to 20% of patients qualify for assistance from foundations or pharmaceutical companies.
- The financial navigator handles the complex enrollment process.

by taking an out-of-the-box approach that involves compassion," she says.

Patients often report their biggest concerns are financial. One stated that the financial navigator "took that burden off my plate and was a blessing during a horrible illness."

A frequent emergency department patient with a chronic condition can be referred to a disability assistance program. A newly diagnosed cancer patient might express concern over the financial burden of treatments. "We refer those patients to our financial navigator to see how we can help," says Adams.

SOURCE

- **Rodney Adams**, Director, Pre-Service and Patient Access, Maury Regional Medical Center, Columbia, TN. Phone: (931) 490-7103. Email: radams@mauryregional.com. ■

Night, weekend staff overlooked — Registrars on off-shifts want pizza parties, face-to-face time

Several years ago, **Shelita Russ**, CHAM, director of patient access services at New Orleans-based Ochsner Baptist Medical Center and Ochsner Medical Center-Kenner (LA), held a pizza party to celebrate a departmental achievement. Her team had met their point-of-service collection goals for the quarter.

When Russ let the night shift know there was plenty of pizza still available for them, she got a less-than-enthusiastic response. "I was trying to doing something good for the team, but it wasn't received that way," she says. "They didn't want to eat a leftover box of pizza from an earlier celebration."

Patient access employees working off-shifts often feel disconnected from the day-to-day operations of the department. "Off-shift employees are just as important as employees that work days. But there is often that divide of the day shift versus the night shift," says Russ. "That is something I learned the hard way."

Whenever a pizza celebration is held for patient access during the daytime, Baptist/Kenner's managers now schedule a separate late-night pizza delivery for the off shifts. "The leadership team will call in and pay over the phone," says Russ. "The pizza is delivered to the staff, or the supervisor picks up the pizza and personally delivers it to the staff."

A yearly picnic is held for patient access week on a Saturday, which the emergency department night shift missed out on. "But leadership actually delivers the team's plates, along with any additional 'goodies' that they may have missed," says Russ.

Face-to-face time

Spotting patient access leaders rounding in the department in the middle of the night goes a long way with off-shift registrars. "By spending 15 minutes with them, they feel acknowledged," Russ says.

Whenever a patient access supervisor works late for any reason, he or she always checks in with ED registrars working the night shift. In addition, a senior patient access manager has an overlapping shift once every pay period that covers several hours of the night shift.

"Instead of working 7 a.m. to 3 p.m., she works from 5 p.m. to 1 a.m. to catch that team and watch their processes," says Russ. "This ensures that processes stay consistent with the processes that we have during the day."

If there is a workflow change, the senior representative works the night shift to assist the team and answer any questions about the new process. Recently, there was a change in the way staff captured a patient's email address during the registration process. "During leader observations and account audits, it was discovered that not all second shift staff were compliant to the new process," says Russ. "Management was able to perform real-time corrections."

Even if off-shift employees have only very basic requests, such as needing notepad paper, they appreciate being able to convey the request in person. "Sometimes they

EXECUTIVE SUMMARY

Patient access employees who work nights and weekends often feel disconnected from their day shift counterparts. Often, they want more face-to-face time with leaders. Managers recommend these morale boosters:

- Occasionally work off-shifts.
- Round in the emergency department whenever you're working late.
- Schedule multiple staff meetings to cover all shifts.

have problems that don't affect the team during the day," adds Russ.

Recently, ED registrars expressed that they were very cold during frigid winter nights because the automatic doors were opening constantly. The problem was addressed by having a single door open instead of both doors.

Occasionally, employees bring up sensitive issues with managers that they would be reluctant to express in emails or voicemails. Even if the employee has no concerns at all, simply seeing leaders makes a difference. "That visual of a leader rounding in their area makes them feel more of a connection," says Russ.

At Cape Coral (FL) Hospital, three staff meetings are now held so all shifts can attend. *(See related story in this issue on encouraging off-shift employees to attend staff meetings.)*

Registration services manager **Jamie Bruner** does these things to help off-shifts to feel connected to their colleagues:

• Staff are broken up into small groups.

Because three staff meetings are held, smaller groups are attending each meeting. About 20 employees attend the first two meetings, and eight attend the third one.

"With the smaller groups, there is no need for break-out sessions," says Bruner. "The group is small enough for everyone to get involved."

• Staff members are asked to bring an item from home and share what it means to them.

"This is a form of adult show-and-tell that brings a bit of fun in smaller groups," says Bruner. "It gives employees an opportunity to connect."

One employee brought in a picture of herself as a waitress when she was younger and worked in a casino. "This was not something the team expected from this employee," says Bruner. "It helped others see there was a lighter, fun side to her personality, which is what I believe she hoped to accomplish."

SOURCES

- Jamie Bruner, Manager, Registration Services, Cape Coral (FL) Hospital. Phone: (239) 424-2659. Fax: (239) 424-4075. Email: Jamie.Bruner@LeeMemorial.org.
- Shelita Russ, CHAM, Director, Patient Access Services, Ochsner Baptist Medical Center, New Orleans/Ochsner Medical Center-Kenner (LA). Phone: (504) 894-2912. Email: sruss@ochsner.org. ■

Make it easy for off-shifts to attend staff meetings — Don't settle for low turnout

Registrars who work night shifts in the emergency department and labor and delivery registration areas can't attend staff meetings, which are held at 2 p.m., at New Orleans-based Ochsner Baptist Medical Center and Ochsner Medical Center-Kenner (LA). However, supervisors give the night shift staff members their own meeting at 10:30 p.m. or 6:30 a.m.

"They hear about updates, such as payer requirements, face-to-face, instead of just reading the information in an email," says **Shelita Russ**, CHAM, director of patient access services.

At Cape Coral (FL) Hospital, access managers were disappointed with the typical turnout at monthly staff meetings. Only about 60% of employees attended. "Many off-shift employees had difficulty attending a meeting that was scheduled during the typical midday meeting hours," explains **Jamie Bruner**, manager of registration services.

The department now has three meetings to cover every shift. First and second shift employees attend one of two 3 p.m. meetings, held on different days. "This hour is a good one because we have first- and second-shift employees overlapping during that time, so the department is still staffed," says Bruner. The meeting for third-shift employees is held at 9:30 p.m. "We didn't want our employees to lose the ability to network with one another from different shifts," says Bruner.

All meetings are held on different days, so employees can attend another meeting if they were unable to attend their own shift meeting. "This adds to the flexibility for team members," says Bruner. "If one day doesn't work for them, perhaps another will."

Managers review all of the same topics at each of the meetings. "We cover our process improvements, metrics, achievements, and goals," says Bruner. "We do celebrations of each other's successes and acknowledge important dates like birthdays."

Patient access leaders attend all three meetings, which required shifting of their hours. "This gives employees an opportunity to see leaders that they would not normally see," says Bruner. "We now have a 90% attendance rate. We consider this a big success." ■

What do staff *really* think of leaders in patient access? Take survey results seriously

Patient access employees at Integris Health in Oklahoma City, OK, weren't shy about letting their feelings be known regarding the department's dress policy.

"We consistently heard they were being mistaken for clinical team members because they were wearing scrubs. We also consistently heard they didn't want to be told what to wear," says **Amber J. Harris**, administrative director of patient-centered access.

The department's policy required female patient access employees to wear black pants, a black scrub jacket, and a shirt of their choice. Male employees wore a shirt, tie, slacks, and black scrub jacket. "We adopted a policy that simply states, 'Patient access team members will dress professionally,'" says Harris. "The reaction was fantastic. They like the freedom to look nice and show their individuality."

Simple changes such as this one can have a dramatic morale-boosting effect, but managers need to act on feedback to satisfy staff, says Harris.

Patient access leaders at Slidell, LA-based Ochsner Healthcare assess employee satisfaction in these ways:

• Patient access staff complete a yearly employee engagement survey.

Employees are asked to agree or disagree with these statements about their managers:

— "My supervisor regularly gives me feedback on my work performance."

— "I would recommend my supervisor to others as a good leader."

— "The evaluation of my job performance by my supervisor is fair and objective."

The manager's score is compared to the "Best in Class" scoring for the healthcare industry. For example, the Best in Class score is 75 for the question on receiving feedback on work performance. "Proudly, I have one patient access manager that scored 77 for performance feedback and 94 as being fair and objective," reports **Tanya Powell**, CHAM, director of patient access for Ochsner's Northshore Region Facility and Clinics.

> "... THEY DIDN'T WANT TO BE TOLD WHAT TO WEAR."

• Patient access departments post a "Stoplight" report on bulletin boards.

A red light indicates the department has complications in meeting a goal. A yellow light indicates that the department is making progress toward a goal. A green light indicates that the goal was met.

"It allows the staff to understand our level of focus and keeps them updated," says Powell. A very large bulletin board, hung prominently in each registration area, posts department metrics including satisfaction scores and point-of-service collections.

• Patient access leaders actively participate in the hospital's Leadership Academy.

Powell recently completed a project measuring the effectiveness of communication in patient access. *[The department's computerized graphic presentation is included with the online issue. For assistance in accessing the online issue, contact customer service at customerservice@ahcmedia.com or (800) 688-2421. Also see related story in this issue on using email surveys to assess staff satisfaction with communication.]*

• Patient access managers ask specific questions when rounding in the department.

Here are three questions that are asked, and feedback is given by staff:

1. What is working well within the department? Staff asked that the house supervisor assist with coordinating patient transport. They also reported that they were

EXECUTIVE SUMMARY

Poor morale of patient access employees might stem from something as simple as a dress code. Patient access leaders must put staff feedback to good use.

- Ask patient access employees to complete a survey about their supervisors.
- Have managers complete an action plan on how they plan to improve.
- Inform staff how concerns were resolved during staff meetings.

continually distracted by employees in other departments. Preoperative nurses and laboratory technicians would frequently ask the registration clerk if they knew where a patient or order was, when the registration clerk was with another patient.

"It was constant interruptions," says Powell. "Now they have to go to the supervisor to inquire. We determine if a rep needs to be interrupted, or we look up the information ourselves."

2. Do you have the tools and resources to perform your job?

Insurance verifiers were frustrated because scanners could be used only by one person at a time. The scanners were reprogrammed for multiple users.

3. What areas require focus and attention?

Emergency department registrars reported confusion on how to properly admit a hospice patient. They also had problems with patient identification.

"Arm banding is now performed by the ED triage team as a second patient identifier, so that patient access does not have to chase down and locate the patient," says Powell.

Staff want involvement

Patient access employees at Peoria, IL-based OSF Healthcare System are regularly surveyed about their opinions regarding their direct manager. Each area receives a score of Tier 1, Tier 2, or Tier 3. Regardless of the score, an action plan is developed.

"Even with a very high-scoring department, there is always something that can be done to make the department better," says **Jessica Atkinson**, patient access services manager.

Atkinson's department managers received a Tier 2 score. "Overall, staff are pretty satisfied. But we still identified an area of improvement," she says. The survey shows that staff members wanted to feel more involved with decisions that affect their work.

"During monthly staff meetings, I now include a slide on concerns that employees had and how they were resolved," says Atkinson.

SOURCES

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- Amber J. Harris, Patient-Centered Access, Integris Health, Oklahoma City, OK. Phone: (405) 713-5547. Email: Amber.Harris@integrisok.com.
- Tanya Powell, CHAM, Patient Access Director, Northshore Region Facility and Clinics, Ochsner Healthcare, Slidell, LA. Phone: (985) 646-5132. Email: tpowell@ochsner.org. ■

Email surveys get quick response from members of patient access staff

When managers at OSF Healthcare System in Peoria, IL, were wondering whether staff members would like a calendar of birthdays set up on the department's internal portal, they asked them via an email survey.

"The majority of employees wanted the option of having their birthday listed there, so they could celebrate with each other," says patient access services manager **Jessica Atkinson**.

At Slidell, LA-based Ochsner Healthcare, patient access leaders asked employees these questions using SurveyMonkey (https://www.surveymonkey.com):

- How satisfied are you with the communication in your department?
- How satisfied are you with the timeliness of information?
- How satisfied are you with the consistency?
- Do you feel you have enough leadership face-to-face time?

"We requested commentary for certain questions," says **Tanya Powell**, CHAM, patient access director of Ochsner's Northshore Region Facility and Clinics. Patient access leaders were surprised to learn that a significant number of staff members didn't like having to attend monthly meetings. "They asked to be communicated to in a better fashion, such as webinars and weekly emails," says Powell.

Staffers want results

After the email survey results were in, Ochsner's patient access managers held a meeting to discuss best practices and opportunities for improvement.

"Many staff commented that 'We do all these surveys, but we never hear the results. Nothing comes of it,'" says Powell. Staff asked for these things:

- more face-to-face time with managers and supervisors;
- communications through webinars for those staff who cannot attend a meeting in person;

• weekly huddles and weekly mass emails to update staff on departmental changes;

• clearer expectations, such as providing specific deadlines for requests, and specific metrics for departmental goals;

• job shadowing to understand others' roles, such as observing patient interviews for Medicaid applications;

• coaching by leaders when critical conversations are needed, such as when supervisors observe an impolite conversation;

• an annual learning retreat for all staff members covering compliance, claims denials, and Medicare Secondary Payer Questionnaire.

The overarching message was that patient access want to feel as though they are part of the decision-making process.

"Engaging the team and taking on their ideas can be a true motivator," says Powell.

Here are two ways patient access leaders at OSF Healthcare obtain feedback from staff:

• Managers round twice a week.

Recently, staff brought a problem with the way high-dollar tests are scheduled to Atkinson's attention. "Because of how the tests are being scheduled, all of them weren't falling to our high-dollar work queue," she says.

If a lab test and MRI were scheduled at the same time, the MRI wasn't flagged as needing an authorization, for example. This issue meant that the authorization had to be obtained at the last minute.

"If that test were to fall under the radar, the patient might have to reschedule," she says. Atkinson asked the employee to provide specific examples of the problem for her to bring to the scheduling manager's attention, so that the process could be changed as needed.

• Managers encourage employees to meet with them individually as needed.

"There are times where staff don't want to discuss an issue in front of a group. Sometimes they don't want to admit they don't know something," says Atkinson.

Other times, employees need to discuss personal issues. Recently, an employee with a business background reported her intention to pursue a nursing career; Atkinson was able to provide encouragement and support.

"To have someone understand the organization from the bottom up is a huge plus," she says. "Who knows? She could be our next chief nursing officer." ■

Paper, storage costs plummet with e-signatures: 60,000 pages no longer printed

Paper costs are now 'minimal' for patient access department

More than 60,000 pieces of paper each month no longer need to be printed, copied, and stored in offsite record storage locations, due to electronic signatures being implemented in registration areas at Ann & Robert H. Lurie Children's Hospital of Chicago.

"We are anticipating a great deal of cost savings as a result of this project," says **Brian M. Stahulak**, MBA, BSN, RN, NEA-BC, administrator of new patient referral.

Registrars no longer need to scan in 30,000 consents each month to the medical record. "This will save a great deal of time for our medical records team," says Stahulak.

Paper costs are now minimal. "Costs for FTEs dedicated to scanning these documents can now be redirected to more value-added projects," adds Stahulak. There are also decreased storage costs. Previously, paper consents needed to be stored offsite in a secure location for several years. "E-signature will allow consents to be stored electronically, safely within the patient record," explains Stahulak.

Patient access leaders at Fairfield, CA-based NorthBay Healthcare are looking at several vendors for electronic verification software. "When you think about a five-page consent form alone, you can easily do the math and figure out that in a year, you've made your money back," says **Lori Eichenberger**, interim senior director of revenue cycle management.

Immediate access

Ambulatory areas recently implemented electronic signatures at Ann & Robert H. Lurie Children's Hospital, but patient access leaders are not stopping there.

"Patient safety, patient engagement, improved workflows, and cost savings are key drivers," says Stahulak. "We are continuously looking for ways we can use it for process innovation." Here are some examples:

• Electronic signatures in the emergency department give

providers immediate access to signed consents and other forms for patients admitted to acute care inpatient floors.

"We have also been able to move a manual process to an electronic one, reducing or eliminating the risk for potential errors," adds Stahulak.

Widespread training

Training was provided to the admitting department, point-of-service staff, and the hospital's transport team.

"There was additional training with nursing teams as well," says Stahulak. "We created a new process for work lists. The admitting team utilizes this to confirm a consent was signed for all admitted patients."

• Electronic signatures are used for consent documents for all hospital-based outpatient centers.

This process allows parents to sign annual consent documents electronically. "Our previous process was that all consent documents had to be signed on paper, labeled with the patient information, and manually sent to medical records for scanning," says Stahulak.

Patient consent documents are now automatically saved and stored within the electronic medical record. "This ensures that all patient consent forms are protected and can be utilized by providers immediately," says Stahulak.

• Electronic signatures are available for families using self-check-in kiosks at registration areas.

"This gives families the opportunity to skip the queue while checking in," says Stahulak.

Hundreds of forms

Patient access leaders at Memorial Hermann Health System in Houston, TX, have used an internally developed electronic signature tool for years. The department is converting to a revenue cycle system from North Kansas City, MO-based Cerner that includes an electronic signature tool.

"We will be going off our 'homegrown' tool in 2016. But we have taken a lot of what we have learned from our existing tool and asked them to build some of that in," says **Tonie Bayman**, director of revenue and recovery for patient business services.

The "homegrown" tool automatically prints the right forms for each patient. Previously, patient access scanned paper forms and then uploaded those to the patient's account.

"We have hundreds of forms. There is a lot of risk in counting on a patient access person to remember which one is needed, and a lot of potential for somebody to forget," says Bayman. Some important forms aren't used often, such as a form enabling self-pay patients to obtain funds for pharmaceuticals.

Patients appreciate not having to sign the same consents multiple times, since the tool flags which forms already were obtained by patient access. "It is a permanent part of the financial and medical records," says Bayman. "And if a visually impaired patient has a hard time reading a form, we can zoom in to enlarge it."

SOURCES

- Tonie Bayman, Director, Revenue and Recovery, Patient Business Services, Memorial Hermann Health System, Houston, TX. Email: Tonie.Bayman@MemorialHermann.org.
- Lori Eichenberger, Revenue Cycle Management, NorthBay Healthcare, Fairfield, CA. Email: LEichenberger@NorthBay.org.
- Brian M. Stahulak, MBA, BSN, RN, NEA-BC, Administrator, New Patient Referral, Ann & Robert H. Lurie Children's Hospital of Chicago. Phone: (312) 227-4622. Fax: (312) 227-9645. Email: bstahulak@luriechildrens.org. ■

EXECUTIVE SUMMARY

Patient access departments can achieve significant cost savings with electronic signatures, due to less paper use and no need for offsite storage. Registrars at Ann & Robert H. Lurie Children's Hospital of Chicago no longer have to scan in 30,000 consent forms each month.

- Providers have immediate access to signed consents for admitted patients.
- Consents are stored electronically.
- Forms are no longer printed.

COMING IN FUTURE MONTHS

- Keep patient access areas up and running during power outages
- Don't allow patients' privacy to be violated during registration
- Ask access employees for honest feedback on colleagues
- Proven solutions for the most challenging payer requirements

Patient ID 'paramount' to forming interoperable LHS

Patient identification has been called "paramount" to the formation of an interoperable Learning Health System (LHS). So says the College of Healthcare Information Management Executives (CHIME) and the Association of Medical Directors of Information Systems (AMDIS).

A joint statement sent by CHIME and AMDIS to the Office of the National Coordinator for Health IT (ONC) asks that patient identifiers be included in the interoperability draft roadmap, reports the National Association of Healthcare Access Management. To access the statement, go to http://bit.ly/1cdaF5e. "Without a standard patient identifier, the creation of a longitudinal care record, composed of data and created through disparate systems, geographies, and chronology is simply not feasible," the statement said. The American Hospital Association (AHA) has asked the government to at least allocate funding to study consumer views about the patient ID system.

The AHA has called the need for a standard patient identifier urgent, notwithstanding the congressional law on the books for more than a decade that prevents the Department of Health and Human Services from creating a unique patient identifier.

The main themes of the CHIME/AMDIS statement are summarized at the beginning of their submission, and they include:

1. Patient identification is paramount if we are to make any progress toward an interoperable LHS. Foundational to the vision espoused by the Roadmap is the ability of providers to accurately and consistently match patients with their data. A national approach to patient identification is prerequisite for interoperability and the lack of a standard patient identifier only serves to aggravate our industry's technical challenges. Without a standard patient identifier, the creation of a longitudinal care record, composed of data created through disparate systems, geographies, and chronology is simply not feasible. Future drafts of this roadmap must enable development of a standard patient identifier.

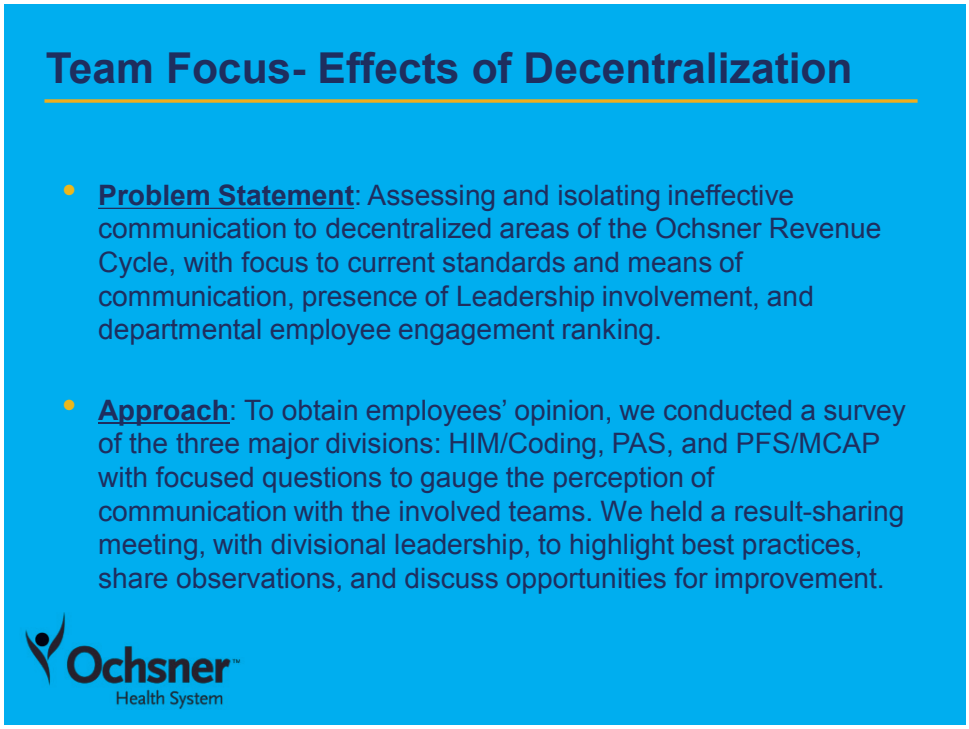
2. CHIME and AMDIS are supportive of the process established by this Roadmap to prioritize standards across several important domains. We also support the concept of a common clinical data set that adheres to clear, enforceable national standards.

3. We caution against being overly ambitious with the development of a nationwide governance mechanism and encourage focused prioritization through ingrained collaboration among private and public sector stakeholders. In our view, interoperability in the service of high quality, safe patient care should remain the principal focus of the near-term.

4. CHIME and AMDIS support the need for additional testing tools, including scenario-based testing and exception handling, and we agree that their development and use are critical actions for stakeholder assurance that HIT is interoperable. We also underscore the need to have a post-certification surveillance program steeped in assuring conformance to requirements established by certification. ■

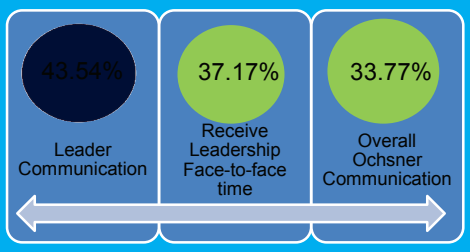
HOSPITAL ACCESS MANAGEMENT™


Effective Communication:
Revenue Cycle Decentralized Areas
Tammy Flair
Lisa Glorioso
Lisa Gunter
Melissa McNaughton
Danielle Peavy
Tanya Powell
James Reech
Tiffany Tucker
Ochsner
Health System

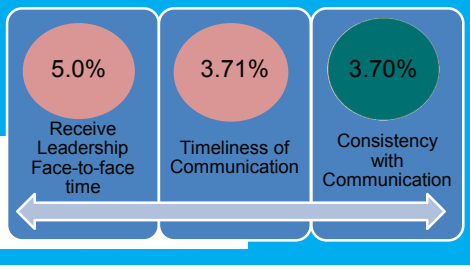

Team Focus- Effects of Decentralization
Problem Statement: Assessing and isolating ineffective communication to decentralized areas of the Ochsner Revenue Cycle, with focus to current standards and means of communication, presence of Leadership involvement, and departmental employee engagement ranking.
Approach: To obtain employees' opinion, we conducted a survey of the three major divisions: HIM/Coding, PAS, and PFS/MCAP with focused questions to gauge the perception of communication with the involved teams. We held a result-sharing meeting, with divisional leadership, to highlight best practices, share observations, and discuss opportunities for improvement.
Ochsner
Health System

Survey Outcomes

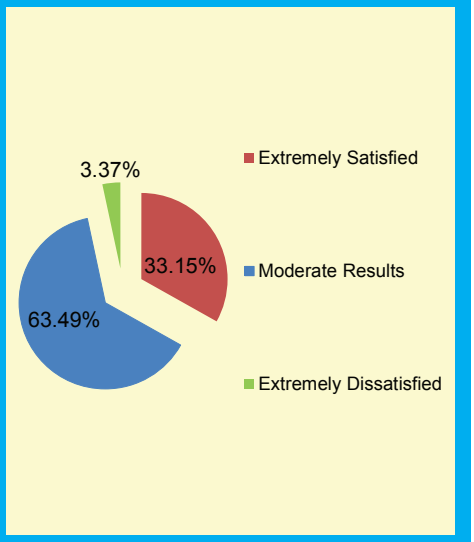
Top Performing



Areas for Improvement



Overall Effectiveness-Survey

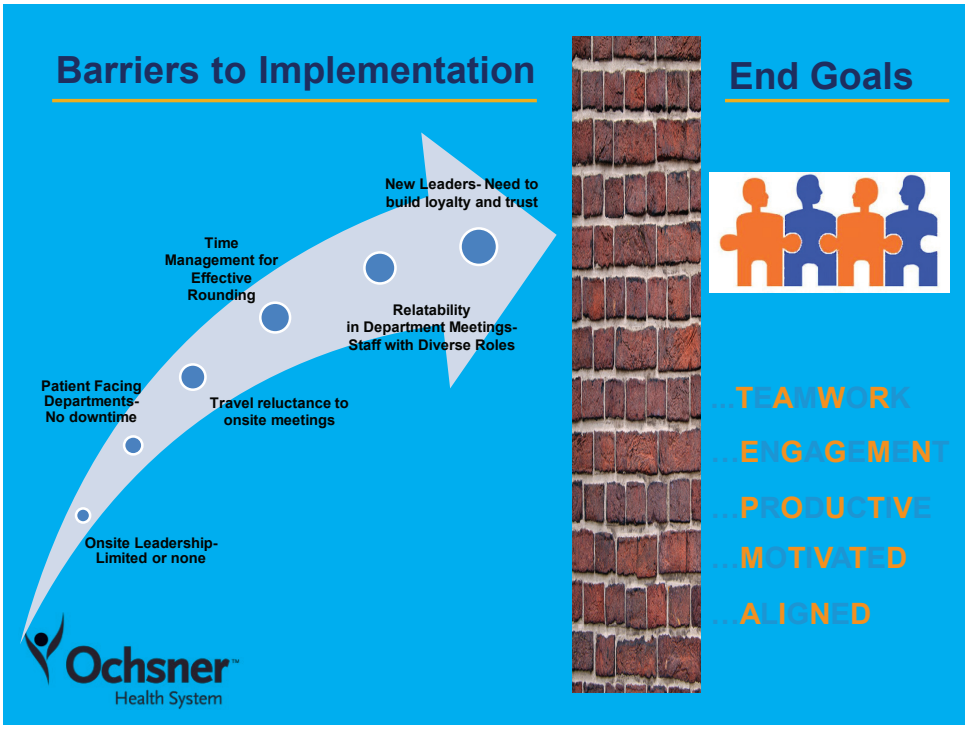


Divisional Focus Group Findings

- **Revenue Cycle Common Processes for Strategic Practices**
  - Meet as a Division Quarterly
  - Have Monthly Staff Meetings
  - Rounding with employees

HIM/CODING	MCAP/PFS-FCC	PAS
Leader at each location	Lack of local leadership presence	Has a leader at each Facility location, not at all clinic sites
Centralization restructure	With diverse departments, trainings and communications cannot be standardized	Have to conduct several dept meetings, different messages
Daily morning huddles	Wide spectrum of engagement	Bi-weekly training huddles
SharePoint access to staff	Use newsletters	Registration refresh investment
After-training assessment	Use email broadcasts	Operational teams give conflicting messages/priorities to staff
Not patient-facing		

Ochsner Health System


Barriers to Implementation
New Leaders- Need to build loyalty and trust
Time Management for Effective Rounding
Relatability in Department Meetings- Staff with Diverse Roles
Patient Facing Departments- No downtime
Travel reluctance to onsite meetings
Onsite Leadership- Limited or none
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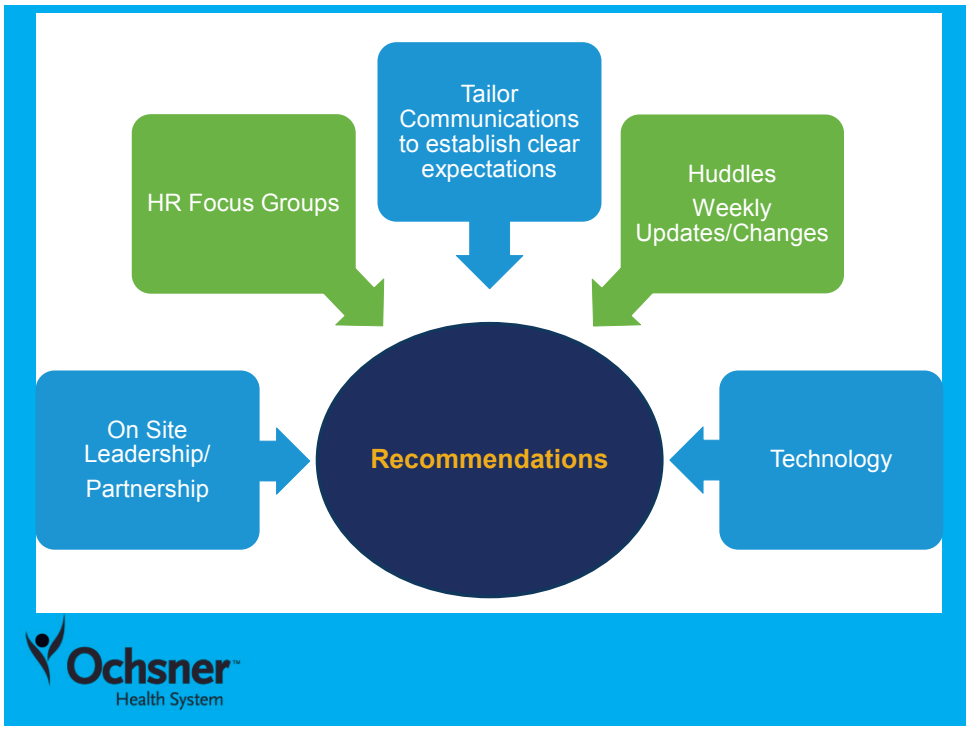
End Goals
TEAMWORK
ENGAGEMENT
PRODUCTIVE
MOTIVATED
ALIGNED


Tailor Communications to establish clear expectations
HR Focus Groups
Huddles
Weekly Updates/Changes
On Site Leadership/ Partnership
Recommendations
Technology
Ochsner Health System

Personalized Interactions Driving Communication

Bridging the balance of Face-to-Face Leadership time

	Patient/Staff Interactions & Duties	Analytics & Admin Time
Senior Rep	85%	15%
Supervisor	70%	30%
Manager	50%	50%
Director	25%	75%

Forging Revenue Cycle and Executive Partnerships at locations

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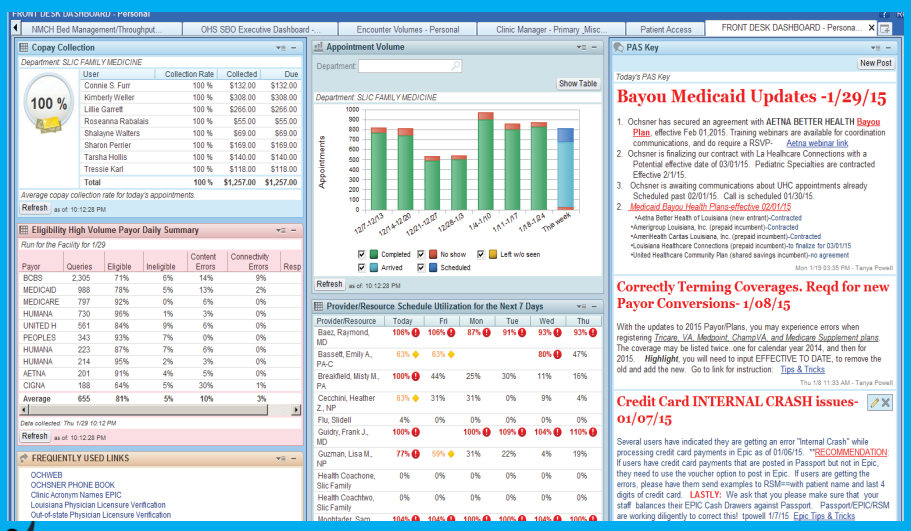
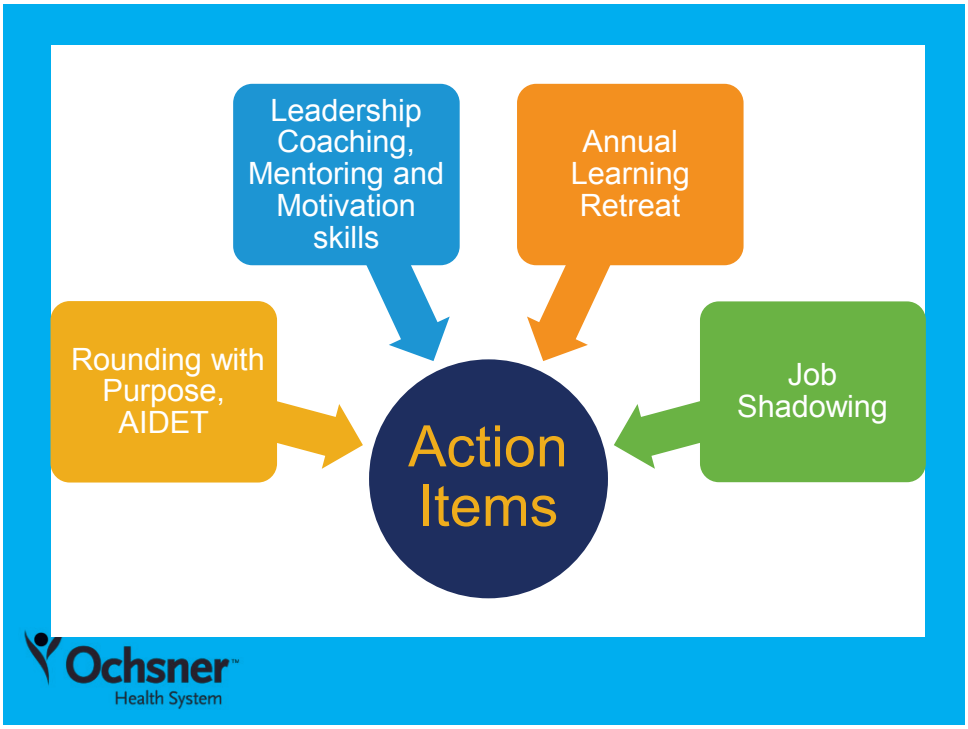
Epic Optimization Driving Communication



Ochsner Health System



Source: Ochsner Healthcare, Slidell, LA.