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INSIDE

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IOM report challenges access to stop needless delays

Front end is said to be 'critically important'

Patient access is "critically important" to achieving the recommendations in a new Institute of Medicine (IOM) report, according to **Gary S. Kaplan**, MD, chair of the committee that produced the report.[1] Kaplan is chairman and CEO of Virginia Mason Health System in Seattle.

Improving access to care "has to start at the foundation," adds Kaplan. "The people at the first points of contact — the scheduler, the reception desk, or call center — are all critical," he says.

The June 2015 IOM report, *Transforming Health Care Scheduling and Access: Getting to Now,* recommends that hospitals do the following:

- continuously assess changing circumstances to match supply and demand;
- put surge contingencies in place to ensure timely accommodation of patients' needs.

"When those systems exist, it's a beautiful thing," says Kaplan. "When they don't exist, inefficiency is manifested by prolonged waits." This leads to not only poor patient satisfaction, he warns, but also suboptimal clinical outcomes. *(See related story on same-day access in this issue.)*

"THE PEOPLE AT THE FIRST POINTS OF CONTACT — THE SCHEDULER, THE RECEPTION DESK, OR CALL CENTER — ARE ALL CRITICAL." — GARY S. KAPLAN, MD, VIRGINIA MASON HEALTH SYSTEM

Kaplan recommends mapping out each step that occurs from the moment a patient attempts to make an appointment. "Waits and delays can occur at every step in that process," he says.

Long waits at registration are one underlying cause of delayed care. **Katherine H. Murphy,** CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of

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Experian Health, says, "There is no guarantee the patient can or will wait and no guarantee they will actually reschedule and make another trip to the provider." Experian Health provides technology for hospitals and healthcare providers.

Pre-registration and pre-service financial clearance are "an absolute must," says Murphy. "This requires proper automated tools and a commitment by patient access to reverse some traditional processes."

Collaboration between patient access and clinical areas is necessary to stop inefficient processes that result in delays. "I have heard many times that the ancillary clinical departments do not want to band the patients or obtain the required signatures," says Murphy. "There must be executive-level support for process change."

Here is how patient access departments can implement the IOM report's recommendations:

• Avoid delays stemming from failure to obtain precertification.

Pete Kraus, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Hospitals in Atlanta, says, "If the physician's office hasn't received the pre-cert, there may be delays with insurance carriers, beyond the hospital's control. This can result in delayed or deferred services."

This potential problem underscores the importance of patient access leaders allocating sufficient staff to obtain prompt pre-certifications. "When pre-cert is not forthcoming, ask the patient to assist by contacting the insurance carrier to resolve the delay," suggests Kraus.

A greater portion of patient access staff should be assigned to the "pre-encounter" process, advises Murphy. "Upon entry, only exceptions should be routed to registration," she says. "The change in process must include as many self-service solutions as possible." *(For more information on this topic, see "Patients will soon self-everything — Apps to revolutionize registration,"* Hospital Access Management*, January 2015.)*

• Make scheduling simpler.

At Lucille Packard Children's Hospital Stanford in Palo Alto, CA, "We have worked on improving the training of our team on communication skills when scheduling and taking away complexity of scheduling," says **Christine Cunningham**, director of the Office of Patient Experience.

Most of the health system's clinics now schedule through the Patient Access Scheduling Center. "A central scheduling model is key for our operations," explains Cunningham. "Many of our patients have complex medical needs and require multiple appointments across several specialty service centers."

EXECUTIVE SUMMARY

A new Institute of Medicine report on wait times, scheduling, and access to healthcare services puts a spotlight on registration and scheduling processes. Patient access leaders can do the following:

- promptly obtain required precertifications;
- offer patients same-day and next-day access;
- register surgical patients in a separate area during peak volumes;
- assign more patient access staff to pre-registration.

• Avoid rescheduling when patients present to the wrong area.

Miguel Vigo IV, revenue cycle system director at Edward–Elmhurst Healthcare in Naperville, IL, says, "Sometimes when this occurs, patients sit in a department and wait to be called, not knowing that they are in the wrong area."

Patient access employees constantly check in with all patients who are waiting to make sure they are in the right location, instead of waiting for patients to approach them. "Some of the patients are not too far away from the correct location. Most of the time, it is a mix-up from one side of campus to another," explains Vigo.

Patient access staff members contact the clinical areas on the patient's behalf. "We alert them that the patient is here on campus, but will need a few minutes to make their way over to the correct area for registration and their scheduled service," says Vigo.

• Avoid problems with physician orders.

Is the physician order signed, dated, with the diagnosis and test clearly stated? **Eston Allison**, MBA, MHSA, CHAM, an access management analyst at Ferrell Duncan Clinic in Springfield, MO, says that if not, "this is a patient flow stopper."

"Just the physician order alone can put up roadblocks for the patient," Allison says.

• Register patients in a separate area during high-volume times.

At Edward-Elmhurst, many surgical patients arrive at the same time to register because multiple procedures are scheduled for 6 a.m. "It's really hard to register 10 patients that all start at the same time," says Vigo.

OR and endoscopy patients register in a central patient access location.

"In order to pull them out of a single, general line for all procedures and outpatient testing, we are working with clinical leaders to develop signage to direct these patients to register in a separate area," says Vigo.

This change will prevent delays that interfere with OR/endoscopy procedure start times.

"Since these registrations take a little longer due to their complexity, it helps to move the outpatient registrations along more timely as well," says Vigo.

ID waste in workflow

Having a "problem statement" keeps the patient access team focused on delay reduction, says Allison.

"The goal should be to increase the speed from the first contact to the patient care service beginning," he says.

Allison gives this example: "Identify the current scheduling process, and redesign the work flow to increase efficiency," he says. "The current time to schedule a new patient is 12 minutes, leading to patient and staff dissatisfaction."

Allison recommends having someone play the role of a patient and following them through the entire process from pre-registration to billing. "Identify the boulders in your patient flow stream," he urges. "Look for waste items."

Here are some examples of inefficiencies in patient access:

• The hospital's admission/discharge/transfer software doesn't "talk to" the system used by referring physicians' offices.

• Pre-certification staff members work with multiple software programs to do their jobs.

• The hospital lacks a patient portal for patients to pre-register themselves, complete paperwork, and pay online.

"This adds time and unnecessary work for registration staff," says Allison. "Many patients would prefer to do as much as they can at their convenience."

• Work flow procedures aren't electronically available for easy access.

"When employees do not have good tools to use, they create their own workflow," says Allison. "This can lead to wasted steps and duplication of effort."

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Same-day access *is* possible, say access leaders

'No show' patient rate is as high as 50% at some hospitals

Patient access needs to develop approaches for "immediate engagement of a patient's concern" at the point of initial contact, recommends a June 2015 Institute of Medicine report, *Transforming Health Care Scheduling and Access: Getting to Now.*[1] This immediate engagement includes same-day service.

"'Open access' can be utilized in many areas, such as ancillary departments and physician offices for primary and pediatric care," says **Eston Allison**, MBA, MHSA, CHAM, an access management analyst at Ferrell Duncan Clinic, a Springfield, MO-based multispecialty physician clinic. Allison says patient access leaders need to do the following:

• Identify the daily average demand.

• Come up with a number of patient slots, based upon historical and seasonal data, that are needed for same-day or next-day appointments.

"Be willing to be challenged in trying something new. Pilot it, and deploy it if it works," says Allison. If appointment slots go unfilled by a specified deadline, he adds, staff should attempt to move up patients if possible so providers stay busy.

"Open access may work best, if there are multiple providers, where only one provider is the open access provider of the day," says Allison.

Same-day access requires careful coordination between the scheduling/pre-services team and ancillary departments, emphasizes **Paige Pop**p, product director at Experian Health, a provider of technology for hospitals and healthcare providers.

"This is especially key to ensuring that patients with insurances requiring 24 to 48 hours to turn around authorizations are not placed into same-day appointments," says Popp.

To avoid claims denials, the same-day process should be automated through the hospital's scheduling application.

"Payer requirements must be linked with appointment parameters," adds Popp.

No-shows at 50%

At Downtown Health Plaza/Wake Forest Baptist Health in Winston-Salem, NC, patient access areas were seeing an uptick in "no shows," as well as extended waits for available appointments.

"Everyone's, including our patients' 'to do list' is getting longer. The priorities of daily life can conflict with medical visits," notes health center manager **Monica Brown**, MPH.

"No shows" cause problems with access because other patients are needlessly turned down for appointments. "Another patient could have been scheduled if the patient cancelled in a timely manner," says Brown.

The closer the appointment time is, the more likely the patient is to show up, she notes. "This is evident in our internal medicine practice, where new patient slots can be several months out from the time of the call," says Brown. "The show rate is approximately 50%."

Same-day/priority access is now offered at primary care areas and specialty clinics. "There are designated slots built into the schedule for each area to accommodate same-day appointment requests and appointments within a specified timeframe," explains Brown.

When a patient calls to request an appointment, patient access staff ask, "When would you like to be seen?" "If the patient responds 'Today,' the rules of same-day access apply," says Brown. "If the scheduler cannot locate a slot, they contact the clinic for options, such as another provider, overbook, or urgent care."

Most open slots are filled on a daily basis. On a given day, in a pediatric practice, about 20 slots are available for same-day and next-day appointments.

When same-day or next-day appointments are made, "patients are more likely to show," Brown explains. "It minimizes the impact of increased throughput that can be created by overbooking patients."

Additionally, clinic hours were extended on weeknights and Saturdays.

"In addition to reducing our 'no show' rate, it also reduces unnecessary ED visits," reports Brown. "We are now looking into text reminders to increase the ease of cancelling appointments."

SOURCE

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Incorrect registration data is a significant patient safety worry

Multiple patients have been harmed, according to recent report

Registration accuracy is "a very significant issue in terms of patient safety," warns **Bill Marella**, director of patient safety reporting programs at ECRI Institute, a Plymouth Meeting, PA-based organization that researches approaches to improving patient care.

"One transposition of a social security number or a patient's first or last names could result in wildly different versions in how their encounter with the healthcare system goes," says Marella.

Incorrect or missing data in electronic health records, including registration systems, was named as one of the top 10 patient safety concerns in healthcare, according to a recent ECRI Institute report. (*The complete report is available at http://bit.ly/1F6juEm.)*

"We've had a number of reports dealing with bad information captured during the registration process," Marella says. *(See story in this issue on actual registration errors that were reported to ECRI institute.)*

Errors caught too late

Many patient access employees have no idea that the demographic information they're obtaining influences what kind of care people receive.

"They may think they are capturing information that just affects billing. But that is no longer true," says Marella.

In many cases reported to ECRI Institute, mistakes made at the time of registration aren't caught until days later. "They go to cut the patient's arm band off. When they go to put a new one on, they realize the information is not right," says Marella.

Every piece of data collected at the point of entry is used by other hospital staff, clinical and non-clinical, throughout the patient's stay, emphasizes **Sue Ojeda**, CHAM, senior manager of revenue cycle management at Tucson (AZ) Medical Center (TMC).

Here are some practices that can prevent registration errors:

• Be sure registrars understand that the information they obtain affects the patient's care, long after they are no longer in contact with the patient.

Marella says, "These reports are coming to us from the patient safety officers in the hospitals. Having them talk to registration professionals about errors that have occurred in their facility might really bring the point home."

• Have an enterprise master patient index.

This index reduces the likelihood of creating duplicate records or associating the current patient with another patient's information.

"Those are the best systems out there for trying to prevent these errors on the front end and help to validate the information that gets sent to HIEs [health information exchanges]," says Marella.

• Simplify the interfaces between systems used by patient access.

"If you are procuring a new IT system, one thing to look at is how it uses data from the ADT [admission/discharge/transfer] system," says Marella. For example, if the ADT system stores patients' first and last names as discrete fields, while an interfaced system stores the names as one field, with last name followed by first name, this difference creates a potential failure point.

"The fewer translations that are made across the dozens of interfaces that exist across a hospital, the less opportunity there is for error," explains Marella.

• Ensure that the patient is identified at the first point of contact.

Ojeda reports, "We recently implemented a new process in our registration areas requesting that all patients presenting for services be photographed."

Patients can opt out if they

EXECUTIVE SUMMARY

Incorrect or missing data in electronic health records is one of the top 10 patient safety concerns identified in a recent ECRI Institute report. Inaccurate registration information can harm patients in these ways:

- Test results might be sent to the incorrect physician.
- The wrong patient's information might be added to another patient's account.
- Incorrect dosages can be given if outdated weights in registration systems are shared with pharmacy systems.

choose, but few do so. Staff use this scripting: "Effective July 13, 2015, TMC would like to take your picture for your electronic health record. This new process will help us ensure we have proper identification prior to your service today and in the future. This will also help us protect you from insurance fraud due to identity theft and/or misrepresentation. You have the option to decline or defer having your photo taken, but we encourage you to do so for your own protection."

Ojeda says, "Over time, we hope to get a picture on every patient's electronic health record."

Patient access supervisors trained every employee on how to position cameras and how to save the photo to the patient's medical record.

"This decreases the number of potential patient identity thefts," says Ojeda. "It also ensures proper identification prior to the patient's services being rendered."

SOURCE

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Patients harmed by registration errors

Here are three cases of registration errors that were reported to ECRI Institute, a Plymouth Meeting, PA-based organization that researches approaches to improving patient care:

• A registrar selected the incorrect doctor from two physicians with the same last name.

This mistake resulted in the wrong doctor's name being placed on the sticker on the chart and the patient consent. "This was then scanned, providing wrong information to pathology. The report was sent to the wrong doctor," says **Bill Marella**, director of patient safety reporting programs at ECRI Institute.

• A registrar at an urgent care center inadvertently entered the patient's information into a different patient's account with the same name.

"Entering a new patient's information on the old account actually changed the information for the other patient as well," says Marella.

• A patient's previous weight was used to calculate drug dosages, instead of the patient's current weight.

"Frequently, information changes between admissions, and some of it is pretty significant," says Marella. An oncology patient's weight was accurately captured in the registration system from a previous visit. However, the patient had lost a significant amount of weight since then. "The pharmacist used the previous weight to calculate the dose and injured a patient pretty severely," says Marella.

The nursing notes reflected the patient's change in weight, but these were not available to pharmacy. Instead, the information in the registration system populated the pharmacy system. "People calculate the doses of some pretty dangerous drugs based on the patient's weight," says Marella. "Sometimes, that's the only information that ends up being available to the pharmacy."

• Outdated demographic information was carried forward from a prior admission.

An elderly patient was brought to the wrong location because outdated demographic information was carried forward from a prior admission. The address given to the ambulance service was incorrect.

"This highlights the risk of registration systems which copy information that was current at the time of the patient's last admission forward to the new admission," says Marella. ■

New self-pay processes stop $5 million in bad debt

'Payment awareness' achieves large collection increases

An additional $4 million in revenue was obtained in FY 2014 at Raleigh, NC-based WakeMed Health & Hospitals from self-pay patients in two of its EDs, with a pilot program starting Medicaid applications during the patients' ED visits.

Without the program, "it would have most likely been charged to bad debt," says registration supervisor **Christopher B. Horton**, CHAM, CHAA.

The cost of the case managers who help ED patients apply for Medicaid is a shared expense between WakeMed and Wake County Health and Human Services. "This service

has been a great asset to both our patients and our organization," says Horton.

Payment awareness

Point-of-service collections for self-pay increased an additional $1 million in FY 2014. Horton credits this to simple "payment awareness."

At WakeMed's EDs, point-of-service collectors are stationed at the discharge exit 24 hours a day, seven days a week. "Our EDs are designed with one way in and one way out, with the discharge desk at the exit of the ED," says Horton. "Nurses ensure the checkout by escorting patients to the discharge area."

Patients are provided with payment plan options and applications for financial assistance. "Representatives verify demographics with the patients and ask them for a service deposit — generally $100 — for both uninsured and underinsured patients," says Horton.

Pre-registration is key

As a public safety net health system, the Phoenix-based Mariposa Integrated Health System (MIHS) sees a payer mix of 35% self-pay patients who are ineligible for Medicaid, 40% Medicaid patients, 8% Medicare patients, 8% with commercial insurance, and 9% with other types of coverage, such as workers compensation, reports **Mary Lee DeCoster**, former vice president of revenue cycle at MIHS. DeCoster is vice president of consulting services for Adreima, a Phoenix-based consulting firm that provides revenue cycle service to healthcare providers.

Patient access leaders at MIHS recently set out to improve these three metrics:

• The percentage of patients with elective services that are pre-registered.

EXECUTIVE SUMMARY

WakeMed Health & Hospitals obtained an additional $4 million in revenue in FY 2014 by starting Medicaid applications for self-pay patients in two of its EDs. Point-of-service collections for self-pay patients increased by $1 million by the health system doing the following:

- asking all uninsured patients for a $100 deposit;
- giving patients payment plan options;
- offering applications for financial assistance.

This pre-registration reduces registration delays at the time of the visit and gives patient access staff an opportunity to collect copays. "It also adds time to verify insurance prior to the visit and initiate securing the authorization if indicated," says DeCoster.

The biggest challenge was simply reaching patients. Many use prepaid cell phones with contact numbers that constantly change.

"Staffing constraints also prevented us from making headway in this area," says DeCoster. "We were always under 50%, well below benchmark."

• The percentage of uninsured patients that are converted to a payer source, primarily Medicaid.

"This metric is closely monitored, as the liquidation rate to collect self-pay dollars from the uninsured is approximately 2.2%," notes DeCoster.

An outside agency is used to determine a self-pay patient's eligibility for Medicaid. "Every uninsured patient presenting to the hospital is evaluated and interviewed, with follow up, for application to Arizona Medicaid, other government programs, or the MIHS financial assistance program," says DeCoster. From 2004 through 2009, the conversion rate ranged from 45% to 48%.

"Then the state cut eligibility criteria, eliminating childless adults. The conversion rate dropped to 25% to 28%," says DeCoster. When the state expanded its Medicaid program in 2014, the conversion rate returned to approximately 48%.

A contracted agency staffed health fairs and weekend events to enroll as many people as possible. "The MIHS enrolled more than 11,000 individuals into either Medicaid or the insurance exchange during the 2014 open enrollment period," reports DeCoster.

• Total point-of-service collections.

"This is calculated against the opportunity to collect," says DeCoster. Patient access employees determine what the patient owes for the particular visit.

"Comparing what was collected against the opportunity, MIHS improved point-of-service collections from the mid-20s to over 50%, over a six-year period," says DeCoster. No patient is turned away for lack of payment. "But each patient is asked for a co-payment," she says.

SOURCES

- Mary Lee DeCoster, Vice President, Consulting Services, Adreima, Phoenix, AZ. Email: marylee.decoster@adreima.com.
- Christopher B. Horton, CHAM, CHAA, WakeMed Health & Hospitals, Raleigh, NC. Email: chorton@wakemed.org. ■

Observe your registrars in patient access — You might find out that you're surprised!

An experienced registrar at UCLA Medical Center, Santa Monica (CA) did her job very well, but had consistently low collection rates. While rounding one day, patient access services manager **Maria Gordillo** found out why.

"As I watched her one afternoon, I noticed she told a patient they could be billed," she recalls. Shortly afterward, Gordillo asked the employee why she didn't try to collect.

"She told me she didn't know how to explain the patient's benefits, so she just told patients we would send them the bill," Gordillo says.

She gave the employee scripting and spent some time instructing her about how to explain insurance benefits. "We saw an increase in her collections almost immediately. She took a little time to gain her confidence, but she came around," says Gordillo.

Jump in to assist

Zander Davis-Washington, director of ambulatory support at Ann & Robert H. Lurie Children's Hospital of Chicago, likes to see how her staff are operationalizing patient access processes.

"It's one thing to put processes on paper. Looking with a deeper eye, you see the reality of how it actually works," Davis-Washington says. *(See story on how the department responded to a switch to Medicaid managed care plans and its effect on front-end staff, in this issue.)*

Davis-Washington and other patient access leaders round first thing in the morning and periodically throughout the day. On high-volume days, they do additional rounding. If they see patients or families waiting, "leaders jump in to assist," says Davis-Washington. "If you have to get on the phone and answer calls or make appointments, that is what you have to do."

By pitching in with such day-to-day tasks, patient access employees "see that you are not just sitting somewhere and giving orders, but are part of the team," says Davis-Washington.

Recently, some employees admitted they felt very uncomfortable requesting copayments from families. Davis-Washington motivated them to collect by sharing collection totals. "Utilizing productivity reports has had a tremendous impact on our collections," she says. *(For more information on this topic, see "Here are best role-playing scenarios to increase your department's collections," Hospital Access Management, August 2015.)*

When rounding, Gordillo is often surprised at what she learns about her staff. "I don't always look for something in particular when I observe them," she says. "I may miss something that I wasn't looking for that can benefit the employee or the department."

Here are some things Gordillo has learned while rounding:

• Members of her staff work very well together.

"To see how much they help each other out was one of my biggest surprises," says Gordillo. "It's something I would have never noticed, had I not been observing them."

She watched her staff members work as a team to get through a recent short-staffed shift and when one employee was having a difficult day personally. "I was able to see their customer service skills, not just for the patient and other departments, but with each other," she says.

• Staff members didn't realize how they affected the next shift.

The evening shift sometimes didn't prepare the appropriate paperwork, which caused the morning shift to scramble.

"If the schedule changed, they didn't print a packet, which consists of a face sheet and a page of labels with the patient's information, for add-ons or direct admits," says Gordillo.

She explained that both shifts benefit by leaving a clean, organized area for the next shift. "They are able to finish faster, which then gives them an opportunity to leave the next shift a cleaner slate," Gordillo says. "It

EXECUTIVE SUMMARY

Observing registrars allows patient access managers to help struggling employees, assess how well staff work as a team, and identify employees' different learning styles. Patient access leaders learned the following during rounding:

- A registrar didn't know how to explain insurance benefits.
- Staff members needed help responding to changes in the state's Medicaid program.
- An employee wasn't using the new insurance eligibility system properly.

continues to roll from one shift to another."

Employees restart computers for the next shift. "Our system uses a lot of memory. If the computers are not restarted, they run slow," explains Gordillo.

Each shift avoids leaving extra work for the next shift. "Staff stay on top of daily tasks that can turn into time-consuming projects, like organizing charts, instead of leaving them for the next shift," she says.

• Staff members were using a new insurance verification system incorrectly.

An employee casually mentioned to Gordillo that she used an outside insurance verification tool, "because the system never works." "When I watched her run for eligibility in our new system, I noticed she missed one simple but key field: subscriber relationship," says Gordillo.

Gordillo instructed the employee to add the field before running eligibility. "It worked, and she was then able to verify with the new system," she says. She then asked other staff how the new insurance verification system was working out. "We found that others were in fact struggling with some of the functionality — something we didn't know until we observed our employees," she says.

• Staff members each learn differently.

By observing employees, Gordillo usually can tell whether they're visual, auditory, or hands-on learners. "Knowing how they learn is one of the most important parts of my job. It teaches me how to present a new process," she says.

Here are some things she looks for:

— Employees who like to explain processes verbally are probably auditory learners.

Gordillo recently explained the differences in consent forms used for various types of patients to a new employee. "She was able to connect it to a previous lesson on outpatient versus inpatient and explain how the consent form applies to each," she says.

— Visual employees often ask managers to "show me."

"That's their key phrase," says Gordillo. "I have several employees that need to see the screen shot of a function to understand what needs to be done."

— A hands-on learner won't feel comfortable even after being shown a process or hearing about it.

Instead, the employee asks, "Can you watch me do one?" "Once I identify these employees, I take the extra time to teach them separately, or I ask them to be the example of the group," says Gordillo. *(For more information on how to teach different types of learners, see "Are access employees struggling with new skill sets? Don't let them fail,"* Hospital Access Management*, July 2012.)*

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- Maria Gordillo, Manager, Patient Access Services, UCLA Medical Center, Santa Monica (CA). Phone: (424) 259-8001. Email: MGordillo@mednet.ucla.edu. ■

Rapid response team helps with Medicaid changes

Patient access managers noticed front end was overwhelmed

"What do you mean, my insurance is inactive?"

While rounding in check-in areas, this statement was overheard by ambulatory support leadership at Ann & Robert H. Lurie Children's Hospital of Chicago. The problem was recent changes to the state's Medicaid program, which switched all families on Illinois Medicaid to Medicaid managed care plans.

"The change is very frustrating for our families. They are not happy to hear the news," says **Zander Davis-Washington**, director of ambulatory support.

Some visits, such as labs and ancillary services, now require referrals. Some plans are no longer in network with the hospital. "That was a big change with our families," Davis-Washington says. "Previously, they never had to manage their insurance. They just showed up with a card."

Patient access leaders saw that staff were unsure of what to tell frustrated, confused families. "We got together as an organization and quickly formulated a plan on how to respond to this," says Davis-Washington.

Immediate response

A Rapid Response Team now addresses Medicaid managed care situations as soon as they occur. "This team consists of subject matter experts on insurance, with in-depth knowledge of how the state is operationalizing this initiative," says Davis-Washington.

Patient access managers were given dedicated pagers so employees can alert them of a problem with a Medicaid managed care plan. "Every

day at 4 p.m., we have a conference call to discuss how these issues were resolved," says Davis-Washington.

Patient access employees educate families on their new plan's requirements. "If needed, families are assisted in contacting central registration to change their coverage and make sure it's effective and in network," says Davis-Washington.

If the plan is not in network, staff inform families that if the plan was auto-assigned by the state, they have 90 days to request a different plan. "A mom can call an 800 number and say, 'I go to Lurie Children's, and this insurance is not in network for them,' and the representative can guide the family to what insurance plan would work best for them," says Davis-Washington.

Many times, the family's coverage is successfully changed to a plan that is in network. "Families end up seeing us as their advocate," says Davis-Washington. "Staff are now confident in addressing this issue." ■

Avoid 'go-live' disasters during system upgrades

"Test, test, test, and retest prior to going live" is the number one lesson learned after patient access systems were upgraded at Ann & Robert H. Lurie Children's Hospital of Chicago, reports admitting director **Robin Speaks**, MSHSA, CHAM.

The department had several rounds of testing to make sure all applications and downstream systems were working as they should.

"When we experienced issues or concerns during the round of testing, we made sure the problems were solved before moving to the next round of testing," says Speaks. Here are some examples:

• Online documents weren't being categorized correctly.

"Our e-signature documents and paper documents were not moving to the correct category, once signed," says Speaks. Instead of being stored as documents on file, they were being stored as "needed" or "expired" documents.

• Patient labels weren't printing correctly.

"We tested printing labels, along with bar codes and face sheets. Everything printed as it should," says Speaks. "However, we encountered problems when we went live."

The enterprise number printed on the patient label, instead of the medical record number. "It was a quick fix," says Speaks. "One piece of advice is to recheck system settings prior to going live."

Patient access leaders at Temple University Hospital in Philadelphia recently upgraded the electronic bed management system.

"Unfortunately, after the upgrade, we experienced significant delays in the overall system response time and numerous downtimes due to server issues," says **Lisa A. Daly**, MHA, director of patient access. Staff members had to revert to manual processes because critical information was dropping off of patient worklists, for example.

"The nuances of a new system affect the current workflow, the overall revenue cycle, and last, but not least, the claim," says Daly.

Taking time to document your current workflow can head off some problems. "If you know how the system upgrade will affect your process flow, you can develop appropriate responses to avoid pitfalls," Daly explains.

Managers might think they know exactly how a certain process is carried out. "However, things sometimes change over the years," says Daly. "For example, instead of receiving paper documents, you now may be receiving phone calls instead."

She found the following items helpful during a recent systems upgrade:

• Daly obtained employee buy-in by asking for input during frequent meetings leading up to the upgrade.

"Change is often times difficult for staff that have been using a system for a long period of time," Daly notes. "Staff possess significant knowledge about both the process and tools."

The bed management staff pointed out problems with the new system's screens. "It just would not work in our environment and would have negatively impacted the overall bed assignment work flow," says Daly. "We were able to make some adjustments prior to go-live."

EXECUTIVE SUMMARY

When upgrading or integrating systems, patient access departments can avoid problems by documenting the department's current workflow and performing multiple tests.

- Ask employees to identify potential glitches.
- Partner with vendors to provide effective training.
- Make sure patient labels print correctly.

• Daly ensured adequate training of staff.

"Partner with the vendor to provide the most efficient and effective training," recommends Daly.

Daly says if she had to do it over again, she would have conducted a mock simulation. "It would have been a great opportunity for us to test a real patient scenario, to make sure we did not overlook anything," she says.

SOURCES

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- **Lisa A. Daly**, MHA, Director, Patient Access Department, Temple University Hospital, Philadelphia, PA. Phone: (215) 707-3438. Email: Lisa.Daly@tuhs.temple.edu. ■

Give patients a friendly face in registration areas

Volunteers take service 'to the next level' by cutting down patients' confusion

EXECUTIVE SUMMARY

Volunteers can improve efficiency and patient satisfaction in registration areas. Patient access leaders are using volunteers to do the following:

- walk patients to their next destination;
- give directions to lost or confused patients or family;
- use pet therapy to alleviate anxiety.

After patients checked in at the outpatient registration area at Thomas Jefferson University Hospital in Philadelphia, PA, they were given a simple instruction: "Have a seat across the hall."

However, many patient still felt confused on exactly where to go in the high-traffic area.

"In order to facilitate a private interview with a registrar, patients are directed to another waiting area, where they are called for registration by the next available registrar," explains **June Parks**, patient access supervisor of outpatient registration.

Now a friendly face, one of six volunteers assigned to outpatient registration, is waiting to escort them. "A patient may not know the routine," says Parks. "Our volunteer cuts down on any confusion a patient may experience, taking our customer service to the next level."

The volunteers, all high school or college students, walk the patient across the hall and direct them to a seat, stating, "A registrar will be with you momentarily to get you registered."

"If they see a patient struggling with bags, they offer to help, or if the patient is thirsty, they get them water," says Parks. "They just look out for the patient and make the process as smooth as possible."

Here are other ways volunteers are used in patient access areas of the hospital:

• Volunteers can give directions.

At Thomas Jefferson University Hospital, patients and visitors often get lost looking for a doctor's office or hospital department.

"Our volunteers are advised to offer assistance to patients and visitors who look lost or confused about their location," says Parks. "They are always there with a smile."

Volunteers are stationed at a central area between the check-in area and the high-traffic hallway. They wear green shirts identifying them as Jefferson Volunteers. "This way they are visible, allowing our patients and visitors to ask for direction and assistance," says Parks.

• Volunteers can provide pet therapy.

At Orlando (FL) Health, registered therapy dogs and their handlers frequently visit registration areas and various waiting rooms.

"This can be an anxious time for patients and family members. Our pet therapy teams light up the room and bring smiles to many faces," says **Amy Flom**, program coordinator for the hospital's PetSmart Paws for Hope Pet Therapy Program.

Visiting with a therapy dog for a few minutes helps many patients to relax and engage in conversation.

COMING IN FUTURE MONTHS

- Avoid dissatisfied patients with registration kiosks
- Stop denials caused by lack of clinical documentation
- Satisfy providers by getting authorizations for them
- Foolproof ways to move up quickly in patient access

"They enjoy a distraction from their hospital issues and, in general, feel more positive," says Flom.

• Volunteers can help out when departments are short-staffed.

Only one registrar works in the outpatient registration department on Saturdays at Cape Coral (FL) Hospital. However, volunteers are there to help by performing simple clerical tasks such as filing, labeling, and preparing charts, as well as keeping the waiting room tidy.

"This frees up registrars to tackle more important tasks," says **Jill Andreasen**, CHAM, director of registration and patient business services.

• Volunteers can alleviate patients' anxiety.

Volunteers are stationed at Cape Coral's emergency departemnt entrance to give everyone a warm, friendly greeting. "This ensures that people presenting for care are identified immediately," says Andreasen.

A patient might be checking with the ED registrar at the arrival desk while other patients walk in and wait to check in. "Having the volunteer stationed at the emergency entrance as potential patients walk in identifies serious conditions immediately, if the registrar is busy speaking with another patient," Andreason explains.

Volunteers also escort patients and visitors to the cafeteria, restrooms, the main lobby, or elevators to inpatient floors. "Oftentimes people entering a hospital are scared and can easily get lost," says Andreason. "Offering some kind words paves the way for a good experience."

SOURCES

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AHRQ tool shows effect of Medicaid expansion

State-level trends in hospital stays

A new online tool from the Agency for Healthcare Research and Quality (AHRQ) shows state-level trends in hospital stays for adults with Medicare, Medicaid, private insurance, and the uninsured. The Fast Stats tool allows users to examine hospital stay information for about 40 states.

Because it includes at least one quarter of 2014 data for 17 states, it can be used to analyze the effects of Medicaid expansion and other Affordable Care Act provisions on hospital utilization levels and payment sources. The tool includes hospital stay information for diabetes, asthma, congestive heart failure, and broad condition categories. Additional conditions will be added over time and updated as new data become available, the agency said. To access the tool, go to http://1.usa.gov/1Ip3TYh. To access the AHRQ statement, go to http://1.usa.gov/1DHdlEl. ■

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