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INSIDE

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Did payer deny claim? Look closely to see if contract allows it

Denial rates could increase by 200%

Many patient access leaders are seeing a sharp increase in claims denials, primarily due to more numerous and stringent payer requirements.

"Claims denials are increasing at an alarming rate," reports **Brinn Leach-Wilson**, a Merritt Island, FL-based consultant with BHM Healthcare Solutions and former director of operations for Rockledge, FL-based Health First.

However, says Leach-Wilson, "it is estimated that around 90% of all denials are preventable and roughly 67% of all denials are appealable."

Leach-Wilson is seeing many more denials due to the Affordable Care Act (ACA) and implementation of ICD-10. "According to an estimate by the Centers for Medicare and Medicaid Services, claims denial rates could skyrocket by 100% to 200% in the early stages of coding with ICD-10," says Leach-Wilson.

Kristin Greenstreet, national business unit leader for healthcare revenue cycle at Navigant, based in Lawrence Township, NJ, says the specific amount of revenue at risk for denials varies, "but industry estimates are that 0.5% to 2% of net revenue is at risk."

In Greenstreet's experience, about 60% of denials are related to front-end processes. Most involve missing authorizations, medical necessity, and timely filing. "There are often situations where an authorization was obtained, but it may have been inappropriately linked to the final bill," says Greenstreet. She says that better clinical documentation by clinicians can prove medical necessity. "Timely filing becomes a 'catchall' for miscellaneous reasons why the payer is not paying," says Greenstreet. "These range from not receiving medical records timely to not receiving appeals."

Greenstreet says patient access needs "an understanding of every dollar due for service. A strong relationship between utilization review, revenue cycle, and managed care also helps."

Examine payer contracts

Recently, a payer refused to give an authorization until the third day of a patient's hospitalization at The Medical Center of Plano (TX). Patient access

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EDITORIAL E-MAIL ADDRESS:
joy.dickinson@AHCMedia.com.

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

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leaders pointed out that the hospital's contractual agreement stated that the authorization needed to be given within 72 hours.

"Luckily, we were able to stop the denial," says the hospital's chief financial officer **Melissa McLeroy**, MBA. "Our in-house payer rep created a process to address this."

The language used in payer contracts sometimes conflicts with changes in payer requirements. For this reason, says McLeroy, "anytime payers make a change, we refer back to our contract. There can be significant revenue at risk."

Lulett Baldwin, revenue analyst for revenue recognition and billing compliance at Mayo Clinic in Phoenix, carefully reviews contracts to be sure payers are meeting their obligations. "Read over the most updated version of the provider manual," she urges. "This is where the payer outlines rules, regulations, and expectations of claim process handling."

To identify underpaid claims, patient access needs to fully understand contract terms and payment obligations. "Research the services billed, contract terms, and provider manuals, to have a clear perspective on the next steps to getting that additional owed reimbursement," says Baldwin.

Some payer contracts state that the timeframe to pay a claim is 30 days, but the payer typically takes 60 to 90 days. Payer reps may indicate the claim still is processing or under review. "But this is unacceptable when the contract has been breached," says Baldwin. "Examples of these claims should be taken to joint operating committee meetings for exposure and resolution."

Recently, Baldwin noticed a surge in denials of Veteran's Affairs (VA) claims sent electronically. "Through reading their provider manual, I learned that these claims must have medical records attached in order to be considered for payment," she says.

Baldwin stopped the denials by working closely with billing to stop the electronic process. "The billers send me a daily email of VA patients," she says. "I print the claim and send it with the medical records. This issue was resolved."

The Medical Center of Plano's denial team looks at all high-dollar denials and also small-dollar denials that are occurring often. "With our denial committee, we have been able to reduce total dollars written off for denials," reports McLeroy.

Writing an effective appeal for a denied claim is essential to receiving a thorough claims review, advises Leach-Wilson. "It takes specific expertise to respond appropriately to each denial," she says. Patient access departments sometimes fail to aggressively manage denials due

EXECUTIVE SUMMARY

Patient access leaders are seeing a surge in claims denials due to increasing payer requirements and in some cases, successfully appealing these denials. Departments are doing the following:

- reviewing contract terms and payment obligations in payer contracts;
- bringing examples of denied claims to joint operating committee meetings;
- building relationships with payer reps.

to lack of resources or conflicting priorities.

"But if denials are not handled correctly or in a timely manner, they can be extremely costly," says Leach-Wilson.

Some denials inevitable

Even the best prevention strategies can't prevent denials from occurring.

Baldwin says, "Payers may delay a claim, deny a claim in error, or completely reject it, as many of us have seen over the years."

While denials are received on the back end at the last stage of claims processing, "the compilation of data submitted on a claim begins with the front end: patient access," she emphasizes. Baldwin recommends these approaches to increase the chances of overturning denials:

• Keep in close contact with payer reps.

"These are the individuals that will give one-on-one attention to your denials issues and work to resolve them," says Baldwin. "Establishing a professional friendly rapport is the best approach."

One way she builds this rapport is by being a familiar face at Joint Operating Committee meetings. "Acquire business cards to start building this network of connections," says Baldwin.

She also schedules one-on-one meetings with payer reps and signs up for email alerts on changes in requirements. "Learn about all the tools and resources they have available," she advises.

• Ensure that patient access employees meet quality expectations when entering patient demographics and insurance information.

"Lack of accurate data retrieved on the front end can result in a denied claim, but can be avoided," says Baldwin.

• Do further research if you see a trend of three or more claims denied for the same or related reason.

Mayo Clinic's Revenue Recognition Department is rolling out a denial report tracking system. "This will assist us in identifying trends to resolve," says Baldwin.

• Provide requested information to the payer in a timely manner.

"In circumstances in which the patient is uncooperative, have a procedure in place to follow that will move this account balance to patient liability," suggests Baldwin.

Unresolved claims issues "causes a domino effect, triggering A/R days to increase," warns Baldwin. "Organizations may not reach monthly or yearly revenue goals because of this." *(See related stories in this issue on preventing denials and appealing medical necessity denials.)*

SOURCES

- Lulett Baldwin, Revenue Analyst, Revenue Recognition & Billing Compliance, Mayo Clinic, Phoenix. Phone: (480) 342-4574. Fax: (480) 342-1949. Email: baldwin.lulett@mayo.edu.
- Brinn Leach-Wilson, BHM Healthcare Solutions, Merritt Island, FL. Phone: (888) 831-1171. Fax: (888) 818-2425. Email: bleachwilson@bhmpc.com.
- Melissa McLeroy, MBA, Chief Financial Officer, The Medical Center of Plano. Email: Melissa.McLeroy@HCAHealthcare.com. ■

5 reasons for claim denials

Here are the top five reasons for claims denials, according to 2015 data from Alpharetta, GA-based RelayHealth Financial:

- registration/eligibility: 24%;
- duplicate claim/service: 18.7%;
- missing/invalid claim data: 13.8%;
- service not covered: 9.9%;
- authorization/pre-certification: 7.9%.

These data highlight areas where patient access can strategically pursue denial prevention, says **John Holyoak**, RelayHealth Financial's director of product management. "Identifying processes and errors that cause denials can have a far-reaching, positive impact on the efficiency of the entire revenue cycle," he adds. ■

Payers claim procedures weren't medically necessary

With medical necessity denials, "prior authorization is 'job-one,'" says **John Holyoak**, director of product management at RelayHealth Financial, which is based in Alpharetta, GA.

"It's frustrating for everyone when the payer determines that the diagnosis provided does not support the need for the service," Holyoak says. "Fortunately, there are options to reverse some of these denials."

Documentation of the patient visit and current medical literature can bolster appeals. "Send copies of your appeal letters to patients, encouraging them to get involved, too," Holyoak advises.

He says that taking these five steps can help patient access departments reduce the number of medical necessity denials:

1. Use technology to alert you of required prior authorizations.

"This eliminates labor-intensiveness of a manual system, such as phone calls or perusing a collage of … notes noting 'what worked last week,'" Holyoak says. Familiarity with pre-certification, frequency, and diagnosis requirements for major payers can be the difference between success and failure, especially with Medicaid claims, he adds.

In some cases, authorization verification is given, but the claim later is denied because the payer says it was never obtained. "This is a very common occurrence," says Holyoak. He advises putting technology in place that provides an audit trail by storing the authorization verification result and date, and a link to the payer website response.

2. Train patient access staff to routinely validate the ordering diagnosis and procedure code against the payer requirements.

If staff members realize that specific documentation or diagnostic testing is required, it could prevent a denied claim.

3. Make sure your claim editing is as strong as possible.

Most payers have rules that change constantly — as often as quarterly. "An edit will alert you to an unmet requirement prior to submitting the claim. This may eliminate waiting weeks only to have the claim denied," Holyoak says.

4. Determine where medical necessity denials are originating.

Was a required prior authorization not completed? Is a particular physician not documenting care adequately? Is a diagnostic test routinely being missed?

"This helps you understand which people in the organization need to be involved and what processes need to be modified," says Holyoak.

5. Use your data to start conversations that need to happen.

In some cases, departments are unknowingly contributing to denials.

"Clear data that shows a particular group or person's contribution to medical necessity denials can help speed change by gaining buy-in," Holyoak says. ■

Prevent denials in the first place — Training is 'paramount'

Errors or typos made by registrars during the collection of information or during the data entry process are "extremely prevalent" in claims denials, according to **Brinn Leach-Wilson**, a Merritt Island, FL-based consultant with BHM Healthcare Solutions.

"This is *not* a good reason to get a denial," says Leach-Wilson. To increase the likelihood of problem-free reimbursement, staff training becomes paramount. "Staff members should be well-versed in submitting clean claims, and even more important, in understanding *why* claims are denied," says Leach-Wilson.

She says leaders of patient access departments should take the following steps to prevent denials, instead of appealing them after the fact:

1. Build a denial recovery unit.

"A good denial recovery unit has three critical functions," says Leach-Wilson. These are:

- denial prevention, which includes developing a standardized process to report failed bill and claim issues, with action expected by the accountable department;
- denial coordination, which entails defining the accountability of each department and defining terms such as "rejection," "revenue loss," and "underpayment";
- denial recovery, which includes establishing rejection and revenue loss trends and write-off rules.

2. Create a denial data database to track the following:

- total claims filed to a payer (number and total charge amount);
- number and dollar value of denied line items.

The data then should be used to calculate percentage denied for the entire organization/system and also by payer, reason, provider, specialty, and location.

"In order to count the number of denials by reason, the organization first needs to determine the categories that will be utilized to track all claim denials," says Leach-Wilson. Then, map the payer reasons to the organization's specific reason categories, such as registration or medical necessity.

3. Collect information from the denial database to determine root causes.

For example, if the database says 10% of denials are due to registration-related issues across three locations in the organization, that's not enough information to act on. The next step is to look at each location to get more specific data, says Leach-Wilson.

The database might reveal that

the three locations have denial rates of 3%, 16%, and 25%. While the first location needs only refresher training, the other locations need process improvement and remedial training. "Without the location-specific data, organizations could expend considerable resources and time in areas that may not affect the outcome," says Leach-Wilson.

Work with payers

At Medical Center of Plano (TX), members of the patient access staff used to obtain authorizations on behalf of physicians, but some payers no longer allow this situation.

"They are saying the physician has to get the auth themselves," says chief financial officer **Melissa McLeroy**, MBA. "That has made it even more difficult for us."

Physicians' offices had to add staff to handle authorizations. "This puts us in the middle, going back and forth between the physician and the payer to find out why authorizations are not yet in place," says McLeroy.

Patient access leaders educate physician's offices on payer requirements in person and build relationships in the process. These personal connections can speed the process of getting authorizations in place, which can prevent claims denials.

"Certain schedulers work with certain physician offices on a regular basis," McLeroy says. "We always try to get a handoff when there's turnover, which happens on both sides." ■

Common registration practices cause big problems with HIPAA

Patients might report violations of privacy

"Mr. Bob Jones? Your colonoscopy will take place in 15 minutes."

If a patient hears this statement said loudly in a crowded waiting room and knows his neighbor or co-worker just heard it too, he'll likely be embarrassed. He also might report the incident as a potential Health Insurance Portability and Accountability Act (HIPAA) violation.

Kenneth N. Rashbaum, Esq., a partner with New York City-based Barton, sees two practices as particularly problematic in registration areas. "One is the registration person yelling out the person's full name when calling the person up," he says. The other is sign-in sheets that make the patient's full name visible. "These are bad practices, for obvious reasons. They disclose the identity of a person waiting for treatment," he says.

The solution is simple, he says: for registrars to use the patient's first name only and to speak to patients in a private area or quietly so that others can't hear the conversation. "The sign in sheet can be covered up, except for the name of the person signing in, or patients can sign electronically with a tablet, so they don't see anyone else's information at all," says Rashbaum.

Most investigations conducted by the Department of Health and Human Services' Office for Civil Rights (OCR) are complaint-driven, he adds. "If a patient complains about improper practices in the registration area, and an investigation is opened, they will probably find other things," says Rashbaum. "This can be the thing that starts the investigation, but it may just be the tip of the iceberg."

Failure to protect patient privacy in registration areas also could come up in a spot audit conducted by OCR. "OCR has been doing spot audits and has announced they will continue to do it in 2016," says Rashbaum. "If they come to the registration area and see these things going on, it's going to be a problem."

In Rashbaum's experience, some patient access employees don't fully understand the need to protect patients' privacy. "Most institutions have some form of HIPAA training, but sometimes registrars are overlooked," he says.

Here are some common practices

EXECUTIVE SUMMARY

Despite widespread focus on the Health Insurance Portability and Accountability Act, some common practices in registration areas can violate patient privacy. Simple changes to protect patient privacy:

- Use only the patient's first name on sign-in sheets.
- Ensure others cannot hear conversations about the patient's medical condition or treatment.
- Get staff members in the habit of logging off whenever they leave their workstation.

in registration areas that can lead to HIPPA violations, according to **George F. Indest III**, JD, MPA, president and managing partner of The Health Law Firm in Altamonte Springs, FL:

• Insufficient physical space and surroundings to ensure privacy.

"Even now, there are some hospitals that have not redesigned or remodeled the areas in which patient registration takes place so as to ensure that conversations cannot be overheard by other patients and those who may accompany a patient," says Indest.

No one should be able to overhear discussions about a patient's prior medical treatment, current illnesses or conditions, and current medications. "We have seen short walls or curtains used that are not soundproof and other physical set-ups that do not ensure privacy," says Indest.

• Failure to have proper procedures and properly trained personnel to ensure that sensitive patient information is discussed only in the presence of the patient alone, unless there is a signed authorization to include others.

"We have been consulted on cases in which a patient's HIV-positive status was discussed in the presence of a neighbor that had brought the patient in to the hospital," says Indest. Another case involved a preliminary diagnosis of a sexually transmitted infection that was discussed with a patient in the presence of her minor children.

> "WE HAVE CONSULTED ON CASES IN WHICH A PATIENT'S HIV-POSITIVE STATUS WAS DISCUSSED IN THE PRESENCE OF A NEIGHBOR ..."

"These types of situations must be safeguarded against," says Indest. "Proper written authorizations must be executed if such a discussion is going to take place in front of anyone other than the patient."

• Failure to ensure that the correct private address at which the patient wants to receive mail and medical bills is obtained and used.

"We have seen bills for lab tests for sexually transmitted diseases sent to ex-spouses because they were the payer for the healthcare insurance for the patient," says Indest.

• Failure to ensure registrars are aware of the facility's privacy practices and the need to ensure patient privacy.

"This should be done with continuing in-service programs; reminders at daily, weekly, and monthly meetings; annual training sessions; e-mail reminders; signs posted in the work area; and other methods," says Indest. *(See related story in this issue on how to create a culture of privacy in registration areas.)*

SOURCES

- George F. Indest III, JD, MPA, President/Managing Partner, The Health Law Firm, Altamonte Springs, FL. Phone: (407) 331-6620. Email: gindest@thehealthlawfirm.com. Web: www.TheHealthLawFirm.com.
- Kenneth N. Rashbaum, Esq., Barton, New York, NY. Phone: (212) 885-8836. Email: krashbaum@bartonesq.com. ■

Create 'culture of privacy' in patient access areas

To prevent potential violations of the Health Insurance Portability and Accountability Act (HIPAA), "we need to, first, cultivate a culture of privacy within the patient access staff," says **Julie Johnson**, CHAM, FHAM, director of patient access and Health Information Management and HIPAA privacy officer at Mount Graham Regional Medical Center in Safford, AZ.

While patient privacy is likely in the forefront of a registrar's mind, says Johnson, security of patient information is less so. "We often think of patient privacy at the front line. However, security of information is equally important," she says.

Johnson gives the example of the HIPAA requirement involving workstation use, which states that physical safeguards should restrict access to authorized users only. "Patients and visitors to the facility should *not* be able to view information displayed on computer screens," says Johnson. She gives these recommendations:

• Make sure workstations are placed in physically secure locations where possible, such as behind lockable doors, or ensure cubicles are not located near an information desk in the lobby.

• Keep patient information in folders to prevent people passing by or standing near the workstation from reading it.

• Position computer screens so they can't be viewed by anyone passing by the workstation.

• Always log off before leaving

your computer unattended, even for the briefest period.

"When training, always have the staff member log off before leaving the area," suggests Johnson. "A few reminders can help this practice to become a habit."

• Give staff members what they need at their fingertips, such as eligibility software, scanning capabilities, and card swipers for payments, to eliminate the need to leave their workstations.

Johnson says to ask these three questions to ensure privacy and security:

• Have employees been trained on security?

• Do employees *understand* the security requirements for the data they use in their day-to-day jobs?

• Is viewing by unauthorized individuals restricted or limited at the workstations?

When the mindset of patient access employees is focused on patient privacy, when staff has been trained and understands security requirements, and when workstations are physically prepared, says Johnson, "a violation is much less likely to occur."

SOURCE

- **Julie Johnson,** CHAM, FHAM, Director Patient Access/HIM, HIPAA Privacy Officer, Mount Graham Regional Medical Center, Safford, AZ. Phone: (928) 348-4027. ■

Record high turnover: Senior registrar role 'slows the flow' out of patient access

In 2014, the patient access department at William Beaumont Hospital Royal Oak (MI) had a record high turnover rate.

"We focused a great deal of energy working with staff to create recruiting and retention strategies to help 'slow the flow' in and out of our department," reports **Cheryl L. Webster**, director of patient registration and hospitality services.

One reason for the high turnover is that more jobs are available at local insurance companies due to individuals enrolling in the Health Insurance Marketplace. Also, many of the department's new hires are recent college graduates looking for a foot in the door. "As soon as they have achieved some real healthcare experience, the staff can find other jobs," says Webster.

The department held a series of focus-group meetings, with employees and managers participating, to obtain ideas on how to reduce turnover. Some participants suggested adding some new positions to allow staff to advance within the department.

"We had already added senior registrar positions that were paid one step higher than the registrar positions," notes Webster. The focus group team suggested adding a few more of these positions.

To become senior registrars, staff members need to meet these criteria:

• at least six months experience as a registrar;

• demonstration of strong performance, leadership, and technical understanding;

• average or higher scores on the most recent performance evaluation in all categories;

• no active corrective action for any reason.

"As a senior registrar, staff serve as the registration equivalent of a charge nurse," explains Webster. Senior registrars handle questions from clinical units and other registration staff. "They have some additional training related to technical corrections that need to occur now and then," adds Webster.

During the final interview with potential new hires, patient access leaders talk about the various advancement opportunities in registration. These include senior registrar, financial counselor, education specialist, and supervisor. "We are hoping to help them think about internal opportunities at the earliest point — *before* they start looking outside of our department," says Webster.

SOURCES

- **Cheryl L. Webster,** Director, Patient Registration & Hospitality Services, William Beaumont Hospital Royal Oak (MI). Phone: (248) 898-0860. Fax: (248) 898-3834. Email: Cheryl.Webster@beaumont.org. ■

EXECUTIVE SUMMARY

Patient access leaders at William Beaumont Hospital Royal Oak were seeing record high turnover rates. They reduced these by doing the following:

- holding focus group meetings to get ideas on how to reduce turnover;
- adding more senior registrar positions;
- informing potential new hires of opportunities for advancement.

Can members of patient access department answer toughest questions about coverage?

Many overwhelmed, confused patients turn to patient access employees to help them make decisions about healthcare coverage and even to obtain coverage. A recent *Health Affairs* policy brief discusses some difficult questions that often come up.[1]

For example, "What is your household size?" might seem like a simple question, but it can be complex if members of extended families share a home. Similarly, a person's immigration status might be unclear in mixed-status families.

Many hospitals have trained patient access employees to be certified application counselors (CACs), who help people fill out applications for coverage, regardless of whether that coverage is Medicaid or a Health Insurance Marketplace plan.

"Although this is an expanded role for hospital personnel, it is not new," says **Sarah Goodell**, an Arlington, VA-based health policy consultant who authored the policy brief. Goodell is a former policy analyst in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

For years, many hospitals helped qualified uninsured patients get Medicaid coverage, even before the Affordable Care Act.

However, says Goodell, "the stakes are higher now with the decline in uncompensated care funds. Hospitals are likely providing additional training to help uninsured patients get coverage."

"Insurance nightmare"

Renee Shores, MAFM, CAC, manager of transplant financial services at Ann & Robert H. Lurie Children's Hospital of Chicago, sees many patients and families with chronic healthcare needs facing high insurance premiums and high out-of-pocket expenses.

"Whether a patient is an accident victim, has received a new diagnosis, or has ongoing healthcare needs, they all have the same question," says Shores. "They want to know, 'Where can I get help navigating this insurance nightmare?'"

Patient access has a responsibility to help families understand their insurance plan and out-of-pocket costs, Shores emphasizes. "With employers and individuals experiencing ever-increasing insurance premiums and out-of-pocket expenses, our goal is to help ease the finance burden by providing individual family counseling," she says.

The maximum out-of-pocket costs for plans purchased on the Health Insurance Marketplace are $2,850 for individuals and$13,700 for families, according to Healthcare.gov.

Families whose income changes make them no longer eligible for Medicaid require specialized financial counseling. "Unfortunately, with more frequency, parents are calling in sheer panic, stating they received a letter informing them they no longer qualify for state-funded Medicaid," says Shores.

They were not financially responsible for medical insurance while covered by Medicaid. However, says Shores, "they are now bearing the financial burden of insurance premiums being deducted from their paychecks and paying for co-pays, deductibles, and out-of-pocket, as well as having to select an insurance plan."

Recently, a parent received a 3% raise that put them slightly over the income criteria for Medicaid eligibility. "Termination of state insurance is a life-changing event that allows access to enroll onto an employer's insurance plan outside of open enrollment," notes Shores.

With their new commercial insurance, the family was able to retain all their healthcare providers, with a monthly insurance premium of $375 deducted from their paycheck. "We helped the family enroll in internal as well as external foundations to assist with their $5,000 deductible and $10,500 out-of-pocket expenses," says Shores.

An "Affordable Care Act Patient Communication Team" at Lurie

EXECUTIVE SUMMARY

Patient access is increasingly taking on the role of helping uninsured patients make decisions about coverage. Following are some ways to ensure staff members are prepared:

- Give specialized counseling to families who are no longer eligible for Medicaid.
- Create a multidisciplinary team to provide educational materials.
- Designate patient access employees to become certified application counselors.

Children's Hospital educates staff and families. More than 50 employees from admitting, social work, and transplant administration share information on patient and family insurance issues.

"Each staff member invests over 10 hours studying for both the Illinois and federal tests to become a CAC," says Shores.

Each department designates one or two individuals to become a CAC. That employee attends workshops on healthcare reform, Health Insurance Marketplace plans, and Medicaid managed care. "Additionally, we instituted super-user 'train the trainer,' which has been incredibly powerful," says Shores.

A group of employees attended several training sessions held by a panel of experts from central registration and managed care. The employees then were asked to share the information with their coworkers.

"Between the Marketplace Exchange plans and the state of Illinois transitioning to Medicaid managed care, providing updated information to the staff is challenging," says Shores.

Like many chronic health conditions, transplantation requires lifelong healthcare services, including pharmacy. "To help combat high out-of-pocket family expense, we actively seek external resources to share with their patients and families," says Shores.

The goal is for families to make a well-informed decision on their insurance plan. "Having the right information will reduce denials and improve access to care," she says. *[The Financial Corner from the department's newsletter for patients and families is included with the online issue. For assistance accessing your online subscription, contact customer service at customer.service@AHCMedia.com or (800) 688-2421.]*

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SOURCE

- **Renee Shores**, MAFM, CAC, Manager, Transplant Financial Services, Ann & Robert H. Lurie Children's Hospital of Chicago. Phone: (312) 227-4608. Fax: (312) 227-9387. Email: rshores@luriechildrens.org. ■

Emergency department registrars work with clinicians to identify "superusers"

Frequent emergency department users are at high risk for bad outcomes

Do you assume that "superusers" of the emergency department (ED), or individuals who present very frequently with the same vague complaints, are just a nuisance?

This assumption is incorrect and dangerous, according to recent research. Patients who present to EDs frequently are more than twice as likely as infrequent users to die, be hospitalized, or require other outpatient treatment, according to a recent analysis of 31 studies.[1]

"We feel strongly that our results highlight a need to regard frequent ED users as a high-risk patient population in the ED," says **Jessica Moe**, MD, the study's lead author and a resident in the Department of Emergency Medicine at University of Alberta in Edmonton, Canada.

Up to one in 12 ED patients is a frequent user, according to the studies analyzed by the researchers, which defined frequent users as visiting from four up to 20 times a year. "The first step in exploring potential interventions to address frequent ED use is to identify the scope of the issue," says Moe. All members of the extended healthcare team, including patient access, can play an important role in identifying high-use ED patients, she adds. Moe suggests these

EXECUTIVE SUMMARY

A novel program at Sinai Hospital of Baltimore avoided charges of more than $200,000 by addressing the needs of frequent emergency department (ED) users. Registrars take these steps:

- Alert care coordinator immediately if a patient has been to the ED recently.
- Look for icons indicating the patient came to the ED in the previous 30 days.
- Scan the census, and watch for familiar names.

strategies:

• Implement flagging systems into existing registration processes.

"This could allow patient access and registration staff to alert physician and key non-physician healthcare professionals, such as social workers or psychologists, about unusually frequent visit patterns," says Moe.

• Implement notification systems initiated at registration to alert key members of the healthcare team when target patients arrive.

"This could facilitate easy access to shared, pre-determined care strategies," says Moe.

Registrars play key role

When ED registrars at Sinai Hospital of Baltimore (MD) see that a patient has been to the ED recently, they let care coordinators know immediately.

"There may be concerns that can be addressed before they see a doctor or a nurse," says **Kathy Salamone**, interim director of patient access.

Care coordinators, stationed in the ED, connect "superusers" to primary care and other resources. **Olympia Ross**, lead care manager in the ED, says, "We set up some specific criteria as a guide for determining who would be eligible."

Three categories of patients are referred:

• "low-risk," which includes patients without insurance;

• "at-risk" patients, which includes patients who presented three or more times in the previous four months, pregnant women without prenatal care, patients without primary care providers, patients with unmanaged chronic diseases, patients who are non-compliant with medications, and patients who lack transportation;

• "super utilizers," who are patients who presented to the ED 10 or more times in the previous four months.

"The patient access team is very good at identifying the super utilizers," Ross says. "They are very well-known to us." Registrars call care coordinators to say, "Mrs. Jones is here again. Maybe you can meet her in triage."

At first, providers relied strictly on icons in the hospital's electronic medical record that alerted them if a patient had been an inpatient admission within the previous 30 days. However, these icons weren't capturing patients who had come to the ED but weren't admitted. A new icon was created, for patients who had come to the ED in the previous 30 days.

"Registrars have access to the same screen and can see the icons as well," says Ross. "They are our first-line defense."

Registrars scan the patient census and watch for familiar names. "We sometimes see them before the provider will," Ross says. "Providers know these patients like the back of their hands but may not have seen them come in."

Fewer barriers to access

The average charge for an ED visit is $1,100.

"We estimate that we avoided ED charges of over $200,000 in the past year, which is a pretty huge savings," says Ross.

The ultimate goal is that people have fewer barriers to accessing healthcare. "We find that in our community, there are, unfortunately, a lot of barriers," says Ross. The vast majority of patients seen repeatedly in the ED for non-emergency needs have no primary care provider, and they have knowledge deficits about how to manage chronic medical problems.

"We see a lot of patients who are simply not connected to appropriate resources or the necessary healthcare providers to meet their needs," says Ross. One patient came to the ED five times in a single month and reported severe depression. A care coordinator connected him to primary and mental health care. "This patient has not been back to the ED since he was referred to the program," says Ross.

Care coordinators sometimes find out that patients are coming to the ED because of poor access to the basic needs of life. One 54-year-old man came to the ED three times in five days. "The care coordinator learned that in addition to having a hernia and no insurance, he frequently went hungry," Ross says.

The care coordinator did three home visits over the next few weeks and determined that the man was eligible for Medicaid and food stamps. "When his Medicaid number came through, he got hernia surgery scheduled and has not visited the ED since," Ross says.

REFERENCE

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SOURCES

- **Jessica Moe,** MD, Department of Emergency Medicine, University of Alberta in Edmonton, Canada. Email: jessica.moe@gmail.com.
- **Olympia Ross**, MSN, RN, ACM, Lead Care Manager, Emergency Department, Sinai Hospital of Baltimore (MD). Phone: (410) 601-9356. Fax: (410) 601-4232. Email: oross@lifebridgehealth.org. ■

Small changes add up to big benefits for access

160 hours of nursing labor saved in four months, with one simple change

Whenever **Sarah Thomas**, senior director of access systems at Seattle Children's Hospital, hears a registrar sigh in frustration, she makes a beeline to that employee and asks what's wrong.

"If you are getting annoyed in the course of doing your job, then you've just discovered an opportunity for improvement," Thomas says. "I want to stir up that conversation."

Like many patient access leaders, Thomas often hears comments such as "Why is that never here when I need it?" "Why can't I get this information more easily?" or "Why am I doing this over and over again?"

"This has identified many problems, which we are then challenged to find solutions for," says Thomas.

The department made these changes:

• The process of referrals from community providers for specialty care was revised.

A team quickly enters these requests into the Epic system, so when the family calls to make the appointment, the information can be brought up right away.

"Nurses need to do a certain amount of triage to make sure we have the right clinical information to connect patients to the right specialty," says Thomas.

This step avoids the patient being sent to a nonsurgical provider if the case is likely to be surgical, for example. However, says Thomas, "we were finding that as much as half of our referrals go unscheduled." The patient's problem might have resolved, or he or she might have gone to the ED in the interim. "If nurses are processing all of these referrals, and only half end up in an appointment, that's pretty expensive triage," says Thomas.

To reduce the amount of upfront work done, nurses go through the process of reviewing the clinical documentation only when the family schedules.

"We tried the new process for a particular diagnosis that was pretty heavy on the records-gathering work," says Thomas. "We saved 160 hours of nursing labor, just with that one diagnosis, in only four months."

• The cost of interruptions was addressed.

While registrars need to multitask and switch between applications, "if you are knee-deep in something and the phone rings, to take that call means you have to retrace some steps," says Thomas.

The department identified the right number of nurses needed to take referral calls, which allows everyone else to work uninterrupted. "We also looked at what kind of work is more interruptible, so registrars can fill in the gaps between phone calls," says Thomas.

• Patient access staff members call providers offices with questions about scheduling, instead of emailing them.

"We were seeing more delays from when the specialty provider gave us new dates for scheduling and when those were actually open," explains Thomas. "It was starting to become a dissatisfier."

The problem is that patient access couldn't schedule those dates until the calendar was open. "We had a five-day turnaround time for requests," says Thomas.

Some requests had errors, such as when the provider indicated a day was open for scheduling, but the provider was out of the office. "The team didn't know what to do without clarifying the request," says Thomas.

Previously, patient access emailed the provider's office, but it sometimes took several emails over a period of days to resolve the issue. "We started a new process, with some good old-school communication," says Thomas. The process was piloted with four specialties.

Patient access now picks up the phone to speak to someone immediately about any scheduling problems that come up. Most can be corrected right away. "Just by getting rid of this back and forth by email, we reduced our turnaround time from five to one and a half days," reports Thomas.

• Reminder calls allow families to cancel appointments with no further action.

The department's previous system allowed families to indicate their desire to cancel, but actually canceling

COMING IN FUTURE MONTHS

- Manage patients with capitated insurance plans
- What to do if a patient presents with a fake ID
- Dramatically increase retention rates in patient access
- Take action if clinicians are rude to registrars

required another phone call. "The delay inherent in reaching each other was starting to become a negative," says Thomas.

Patient access found that an update to the system allows families to cancel on their own, with no further action required by the family or patient access. "By solving a problem for our families, we actually eliminated work for our staff," says Thomas.

Fewer families need to be called back to confirm the cancellation. Michelle Harkins, manager of scheduling and intake, says, "This allows us more time to be doing what we do best: taking incoming calls from our patients and families who are ready to schedule appointments."

Previously, it took about 40 minutes a day to make the calls; it now takes half as long.

"In the 20 minutes we save, we can schedule four appointments," says Harkins.

SOURCE

- **Sarah Thomas**, Seattle Children's Hospital. Email: Sarah.Thomas@seattlechildrens.org. ■

Shorter surgery check-in saves $11,500 plus a minute per case

Patient access employees, supervisors, and managers at Seattle Children's Hospital are constantly on the lookout for work that is no longer useful.

"We are good at adding work in. We make sure we are removing as much as we are adding," says **Sarah Thomas,** senior director of access systems. A recent change involved the surgery check-in process.

Patient access verified only certain items for clinic check-ins. However, for surgery-check-in, they verified every piece of information on a patient's record.

Registration manager **Sara Dunn** says, "The emphasis on accurate information for invasive procedures compared to outpatient clinic exams was what we had always done — historical due-diligence — even if the patient had just been in for a preop appointment days before the surgery."

Cindy Hutchinson-Iverson, a family service coordinator, saw that some of the work was redundant, and she lobbied for change. "It was a frustrating process, and I could see how stressed families were the day of surgery, so I asked 'Why are we doing this?"' says Hutchinson-Iverson.

For surgery check-ins, staff now verify only the fields that require verification. Dunn says, "We are relying on our systems to work for surgery check-ins, just as we know they do for clinic check-ins." Average time for surgery check-ins decreased from six minutes to five minutes. "This calculates to a 0.2 FTE savings," says Dunn.

While just one minute is cut from each surgical registration, says Thomas, "when you multiply the reduced cycle time by hundreds of events in a month, it increases our capacity significantly." The new process saves the department $11,500 in per diem coverage. "The great thing about it is it isn't just a cost savings. This is a better experience for our families," says Thomas. "They don't want to sit with us any longer than necessary." ■

HOSPITAL ACCESS MANAGEMENT™

"Financial Corner" from Spring/Summer 2015 newsletter

Each addition of a biannual newsletter for transplant patients and families at Ann & Robert H. Lurie Children's Hospital of Chicago features a "Financial Corner." This feature covers healthcare insurance issues to help families become more informed about their options. Below is a planning tool included in the Spring/Summer 2015 newsletter, which lists important questions to ask before choosing a new insurance plan during open enrollment.

My employer changed insurance plans. What questions should I ask?
The following checklist can help you evaluate your current health plan, as well as assist you with considering new option during employer open enrollment or choosing a new insurance plan. Please the below questions as a guide to speak with your employer or other entity offering health insurance benefits:

Financial Considerations

How much is annual Deductible? $_____
How much is annual Out-of-Pocket? $_____
Copay's for specialty visits, ER or inpatient admissions? $_____
Does the policy have Out-of-network benefits?
How much are pharmacy Co-pays? $_____

Choosing a Provider

Can you use your same Primary Care provider? YES/NO
Is Lurie Children's Hospital In-net-work? YES/NO
Are all Specialties or current medical team in-network? YES/NO

Evaluating Your Coverage

Does this policy require referral or authorization (X-ray, MRI, or Cardiac catheterization)? YES/NO

Rehabilitation services, including physical, speech and occupational? **YES/NO**
Does this policy cover anti-rejection medications? **YES/NO**
Which retail pharmacy is in-network (Walgreens, CVS, Walmart specialty, etc.)? **YES/NO**

Understanding Health Insurance Language

Deductible — the amount you must pay each year before your plan begins paying

Coinsurance (out-of-pocket) — the amount you must pay for medical care after you have met your deductible. Typically, your plan will pay 80% of an approved amount, and your coinsurance will be 20%, but this varies from plan to plan.

Copay — the flat fee for various medical services — for example, $20 each time you visit the doctor.

Formulary — an insurance company's list of covered drugs.

Group insurance — health plans offered to a group of individuals by an employer, association, union, or other entity.

Health maintenance organization (HMO) — a form of managed care in which you receive all of your care from participating providers. You usually must obtain a referral from your primary care physician before you can see a specialist.

Health savings account (HSA) — an account established by an employer or an individual to save money toward medical expenses on a tax-free basis. Any balance remaining at the end of the year "rolls over" to the next year.

High-deductible health plan — a plan that provides comprehensive coverage for high-cost medical events. It features a high deductible and a limit on annual out-of-pocket expenses. This type of plan usually is coupled with a health savings account or a health spending account.

Source: Ann & Robert H. Lurie Children’s Hospital of Chicago.