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INSIDE

AHC Media

Want More Respect for Access? Get Involved in Safety Initiatives

A patient presents for an outpatient test without any form of identification. He misquotes his date of birth and uses a nickname instead of his real name when giving his information to registration.

This is a common, and potentially dangerous, scenario in registration areas. "Now, more than ever, clinical leaders are seeing that patient access plays a huge part in the success of avoiding patient safety events," underscores **Coleste S. Amerson**, CHAM, manager of patient access at Northside Hospital – Atlanta.

"NOW, MORE THAN EVER, CLINICAL LEADERS ARE SEEING THAT PATIENT ACCESS PLAYS A HUGE PART IN THE SUCCESS OF AVOIDING PATIENT SAFETY EVENTS." — COLESTE S. AMERSON, CHAM, NORTHSIDE HOSPITAL – ATLANTA

In this hypothetical scenario, registrars likely would create a new account and new medical record number, which means care providers wouldn't be aware of the patient's medical history or allergies. If the patient was admitted to the hospital and had a contrast dye allergy, the admitting team wouldn't know about it, which potentially could result in an intensive care unit admission.

In cases such as this, says Amerson, "if the patient had presented with photo ID, it would have been found at that time that he already had a medical record number in the system. His previous medical history and allergies list would have been documented accordingly."

Immediate care

As the "front door" of the hospital, patient access employees usually are the first people that patients encounter. In some cases, registrars need to do more than schedule or check in a patient; they need to respond to a need for immediate medical care.

"Staff in patient access areas aren't typically clinically trained, so they need tools to help them recognize and appropriately handle urgent and emergent situations," says **Michele Tierney**, revenue stream manager at Seattle-based

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Virginia Mason Health System.

The patient access team worked with the Primary Care Department to develop *Urgent/Emergent Guidelines*. **Karen Layher**, manager of Virginia Mason's Call Center, says, "Schedulers use this resource to ensure individuals calling to schedule an appointment will be safe until coming in for their scheduled appointment."

Patient access team members use the tool to direct patients to appropriate care. "These guidelines are used by all staff members who take incoming calls and also by team members at our access points," says Layher. After hours, hospital operators use the same guidelines to direct patients to providers or nursing resources.

"Patient access staff were involved in creating these guidelines, using the continuous-improvement processes of the Virginia Mason Production System, the organization's management methodology," says Layher.

At Washington, DC-based Sibley Memorial Hospital, a stroke coordinator gives a quarterly in-service to registrars on symptoms of stroke and instructs them to call the stroke response line if they suspect a patient might be having a stroke. "Even as a nonclinical department, we can still see the signs. If you are not sure, it's better to call the number, than not to," says **Katherine Narbonne-Mirchin**, MBA, operations manager for the Admissions Department.

Amerson sees a unique role for patient access in patient safety, by serving as the patient's initial contact. "We have an opportunity to provide the first level of protection against any unfortunate patient safety event," she says.

Northside's registration areas clearly post key phone numbers, such as security, so it is easy for an employee to call for help. Amerson says patient access should be prepared to provide a patient with any assistance necessary.

"In an urgent situation, they may need to help stabilize the patient prior to a medical provider arriving," she says. "This could simply be ensuring all patient access employees are CPR-certified."

Head off problems

Patient access should participate on any hospital committee centered on compliance with The Joint Commission standards, compliance, regulations, or quality — particularly patient flow or patient throughput, urges Amerson. *(See related story in this issue about patient access' involvement on patient safety committees.)*

Such committees "are a great forum to share any barriers patient access leaders are seeing that relate to patient safety and

EXECUTIVE SUMMARY

Patient access areas can greatly improve relationships with clinical areas by getting involved in organizationwide patient safety initiatives, according to hospital leaders.

- Train registrars to respond if patients need emergent medical help.
- Represent patient access on compliance, quality, regulations, and patient flow committees.
- Cite examples of surgical patients who presented without identification due to lack of clarity by the pre-assessment team.

how those can be a delaying factor when moving a patient through the organization," Amerson says.

In Amerson's experience, resistance to patient access being part of clinical meetings and discussions "is almost a thing of the past."

If patient access leaders do encounter outdated attitudes, it is important to speak up, Amerson adds. "Provide real examples of issues that could have been avoided or caught sooner if patient access was involved," she suggests.

One common problem is that patients often are told during their pre-assessment call, usually facilitated by the clinical team, not to bring any personal belongings with them when they present for surgery. Some patients take this literally, and don't bring anything with them, not even a photo ID.

"Patients are, at times, confused during a stressful event in their lives such as major surgery," says Amerson. When patients present to registration, it is easy for them to misquote a date of birth or even misspell their own names. "Anything is possible when a patient is nervous and not thinking clearly, because they are worried about the test or procedure they are about to have," says Amerson.

The pre-assessment team should clearly state that the patient needs to present with their photo ID and insurance card if appropriate. "Not presenting a photo ID when presenting for registration could lead to a patient identification issue, which in turn could lead to a patient safety event," warns Amerson.

SOURCES

- **Coleste S. Amerson**, CHAM, Manager, Patient Access, Northside Hospital – Atlanta. Email: coleste.amerson@northside.com.
- **Karen Layher,** Call Center, Virginia Mason Health System, Seattle. Phone: (206) 341-0664. Email: Karen.Layher@virginiamason.org.
- **Michele Tierney**, Revenue Stream Manager, Virginia Mason Health System, Seattle. Email: Michele.Tierney@virginiamason.org. ■

Admissions Gives Valuable Nonclinical Input

The Admission Department at Washington, DC-based Sibley Memorial is very involved in the hospital's Comprehensive Unit-based Safety Program (CUSP), a patient safety-focused change model developed by The Johns Hopkins Hospital.

Johns Hopkins Hospital has 140 CUSP safety teams in all parts of the organization, including nonclinical areas such as the pharmacy, laboratory, blood bank, and admissions.

"We have made major improvements in the department. Physician and nursing experts on the committee give us the clinical background we need to make changes," reports **Katherine Narbonne-Mirchin**, MBA, operations manager for the Admissions Department.

Recently, the department made changes to be sure a patient's information isn't mixed up with the next person's. "We have a checklist where the staff member reviews all the information with the patient to make sure it's correct in the system. If not, they will correct it right then and there," says Narbonne-Mirchin.

At registration areas, staff members are required to use hand sanitizer, face masks, and gloves for added protection. **Lina Jariri**, financial counselor and CUSP unit champion, says, "We make sure staff are aware that if they are sick, they are to put on a mask and apologize to the patient."

The department creates a matrix each week to track patient safety-related improvements. "From that, we can see what our percentages are, and what we need to work on," says Jariri.

One area of focus is complimenting clinical departments, so patients expect a good experience.

Narbonne-Mirchin says, "Clinical areas tell us patients are coming in with a positive attitude. We are getting positive feedback from patients as well.'"

Being part of CUSP has greatly improved relationships between patient access and clinical areas. Jariri says, "We are striving to make it a known fact that even though we are nonclinical, we can still work with them. We are all on the same frame: to make sure that the next patient isn't harmed."

Admissions was the only nonclinical department to present at a recent Johns Hopkins Medicine Patient Safety Summit. "A lot of nonclinical groups from offices within the Johns Hopkins Network asked us to show them how they can do this at their facility," Jariri says. "That was a great feeling."

Join clinical committees

Seattle-based Virginia Mason Health System's admitting manager plays an active role on the hospital's stroke team. **Michele Tierney**, revenue stream manager, says, "A quick admission for a stroke patient is paramount to facilitating quick treatment and better outcomes."

The admitting manager provides

valuable input from the patient access perspective. "Patient access is sometimes left out of the clinical conversations," notes Tierney. "We have learned to affirm our important place in these conversations."

This involvement comes into play with the standard process used for all potential stroke patients coming to the hospital's ED. "[Compliance] is reviewed monthly and reported back to the team members, including patient access staff," says Tierney.

Admitting is routinely involved in conversations about how processes can be further improved. "This supports quality care, improves patient safety, and enhances the total patient experience," Tierney says.

At Virginia Mason, a multidisciplinary team, including admitting, security, housekeeping, and emergency department (ED) staff, meets monthly to create processes to improve patients' experience in the ED. The group, which includes staff members, focuses on privacy, comfort, staff courtesy, and the physical environment. "It advanced more quickly than it might have, had it only been driven by executives or other senior management," says Tierney.

SOURCES

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- Katherine Narbonne-Mirchin, MBA, Operations Manager, Admissions Department, Sibley Memorial Hospital, Washington, DC. Telephone: (202) 370-6591. Email: knarbon1@jhmi.edu. ■

It's Coming Soon: Drivers' Licenses on Smartphones

Technology being piloted could make patient verification process easier

In the near future, registration areas might identify patients using drivers' licenses — on smartphones. Iowa is piloting mobile drivers' licenses, and states including Delaware, California, Arizona, and New Jersey are considering doing so.

If there was an electronic driver's license that could be embedded in the registration system, it could save a step, says **Cynthia Hamilton**, director of business and financial systems at Parkland Health & Hospital System in Dallas. "If you did a demographic query and the person's electronic driver's license was returned with his other demographic information, the process of verifying the patient would be easier," she explains.

Self-service kiosks are used at some of Parkland's outpatient clinics to identify patients, but utilization isn't as high as the department expected. "The challenge that we face with the kiosks is with the workflow," says Hamilton.

In the hospital's OB/GYN clinic, for example, patients are given pagers similar to those used in restaurants, while waiting to be registered. If patients sign in at the kiosks, they still have to stand in line to receive the pager. "Therefore, they eliminate one step by going directly to the sign-in line," says Hamilton.

Fewer patients use the kiosks, since the functionality is limited to just signing in for the appointment. "We plan on increasing functionality in the next few weeks to allow the patient to check in to the appointment with additional functionality," says Hamilton. "This should increase the use of kiosks."

The kiosks offer these four ways for patients to identify themselves:

- They can use their names, dates of birth, or zip codes and the last four digits of their social security numbers.
- They can use their medical record numbers in place of their names.
- They can swipe their credit cards or drivers' licenses.
- They can use palm vein identification, which scans the pattern

EXECUTIVE SUMMARY

Patient identification processes in registration areas will change once mobile drivers' licenses, which are being piloted in Iowa and considered by other states, are implemented. This change could eliminate the problem of fraudulent identification. Some other cutting-edge approaches:

- Patients are given pagers while waiting to be registered.
- Patients are using palm-vein technology at kiosks.
- Patient photographs are taken at registration and displayed on electronic medical records.

of veins on the users' palms. This technology allows the registration staff to ensure they have the correct patient every time.

"There is no need to scroll through long lists of similarly named patients to find the correct one, or create a new record if demographics are slightly off," says Hamilton.

While palm vein scanning is the most accurate way to identify patients, it's not yet available in every clinic location at Parkland. "As we expand our palm vein scanning housewide, we will see a greater reduction of duplicate records," says Hamilton.

One barrier is the cost of device implementation. "There are many points of entry for registration that all need devices," says Hamilton. "The challenge is to make sure high patient volume areas are able to utilize the technology efficiently."

Some patients remain leery of the palm vein identification. "They have concerns about who would have access to their record, despite staff explaining the process and safeguards to them," says Hamilton.

Another recent change is that patient photographs are taken at registration. These photos are displayed in the Epic header, order entry screen, and medical administration screen.

"We are in the early stages of implementing this technology," reports Hamilton. "This will add an extra layer of safety to the identification of the patient during their visit."

SOURCE

- Cynthia Hamilton, Director of Business and Financial Systems, Parkland Health & Hospital System, Dallas. Phone: (214) 590-4774. ■

What Patient Access Must Know about Capitated Insurance Plans

Significant revenue could be lost if patient care isn't closely managed

A growing number of patients are presenting to registration areas with capitated insurance plans. These plans allow payment of a flat fee for each covered individual, regardless of how much care the individual receives.

"Because these types of plans essentially create a 'budget' per patient for care, providers want to ensure that their patient is well and healthy and that they are closely managing the cost of their care," says **Yaroslav Voloshin**, vice president of revenue cycle advisory solutions at MedAssets-Precyse, an Alpharetta, GA-based firm specializing in revenue cycle services and technology. Once the cost of care reaches the cap, providers won't be reimbursed for any additional care.

"Patient compliance is a big part of this, especially when it comes to taking medications," says Voloshin. If patients don't take their medications as prescribed, for example, they are more at risk of developing costly complications.

Automated reminders are one way that hospitals can improve compliance with medications. "Hospitals are also assigning nurses to help monitor patient compliance on an outpatient basis," says Voloshin.

The goal is to manage capitated patients in the most efficient way possible, which lessens the possibilities of complications that would require hospitalization. "The industry as a whole is moving in this direction," says Voloshin. "The goal is to manage wellness and avoid hospitalization as much as possible."

Much revenue at stake

Amy Sherman, CRCP, director of patient access at Berlin-based Central Vermont Medical Center, worries that capitated plans will negatively impact the hospital's bottom line.

"Some private practice physicians won't take patients with this kind of payment structure," she explains. If patients with capitated plans don't see a primary care physician because

EXECUTIVE SUMMARY

Patients with capitated insurance plans, which give providers a flat fee regardless of how much care is provided, are increasingly presenting to registration areas.

- Once the cost of care reaches the cap, providers won't receive additional reimbursement, so it's important that patients are compliant with their care instructions.
- Automated reminders could reduce non-compliance with medications.
- Some hospitals have nurses monitor patient compliance on an outpatient basis.

they can't afford to pay out-of-pocket costs, their condition might worsen. Some of these patients will end up in the emergency department or be admitted to the hospital.

"A hospital in network absorbs such great costs to care for very ill patients that it becomes a financial drain on organizations," says Sherman.

Some systems lack resources to ensure distribution of correct reimbursement according to payer contracts. If a hospital has staff trained in proration rules, which can identify payments that are not following the contracted rate, and an underpayment department focused on capturing any shortfalls, "then you are in a great position," Sherman says.

Smaller hospitals, however, must rely on individual billers' knowledge and expertise about insurance remittance advice, which explain reasons for payment, adjustment, denial, and/or uncovered charges. "There is no easy way to identify [underpayments] without knowing your contracts and being able to identify when payments have not been advanced," says Sherman.

It's key to have staff to "push back and fight for corrected payments when appropriate," Sherman says. Not every hospital does, however. Central Vermont Medical Center sometimes outsources high-dollar denials.

"Once appeals have been exhausted, we use a health law firm in Baltimore," says Sherman. "This offers us a level of expertise not found in organizations that don't have legal counsel."

SOURCE

- Amy Sherman, CRCP, Director, Patient Access, Central Vermont Medical Center, Berlin. Phone: (802) 225-7560. Email: amy.sherman@cvmc.org. ■

Use Quality Assurance Tools to Identify — and Fix — Errors *Before* Claims Go Out

Hospital registrars held accountable for clean claims

Patient access leaders at Marion (IN) General Hospital wrote rules, tested, and trained more than 70 registrars before going live with a new electronic quality assurance (QA) tool in March 2014. The tool (AhiQA, manufactured by Alpharetta, GA-based Relay Health) allows registrars to see errors right after the registration is complete, so they can correct them immediately,

Prior to implementing the tool, "QA was tracked manually as best we could," says patient access manager **Teresa Adams**, CHAM.

Some registration areas reported errors through their own clinical departments instead of patient access. "Some non-reporting departments were negatively impacting the overall QA results, with as low as 79% quality outcomes," says Adams.

Staff members find it challenging to complete registration QA checks, especially if registration is a small percentage of their overall duties, adds Adams. The time commitment needed for training on completing accurate registrations is another challenge. "Clinical areas have a small quantity of cross-trained staff to cover while core registration personnel are attending training," Adams explains.

Overall QA at 98.94%

Although the hospital's overall QA score was about 95% — patient access wanted to improve it further. They set a target of between 97% and 100%.

"We realized there would be a transition while staff were on a learning curve," says Adams. During the transition, managers still were tweaking the QA tool, by evaluating the rules that were installed and creating new ones.

Staff sometimes misinterpret a rule as "invalid/no action required." "However, if they do not dispute the error, we will not be able to review and accept their dispute," resulting in an unfixed error, says Adams. This process results in a lower QA score for the individual employee and the department.

EXECUTIVE SUMMARY

Patient access departments are increasing registration accuracy with quality assurance tools, which results in more "clean claims" and reduced accounts receivable days.

- Outcomes may worsen initially, due to increased number of data elements.
- Registrars are coached right after the error is made.
- Training time is reduced, due to built-in rules and edits that catch errors.

Disputes allow patient access leaders to clear the error from being counted against an individual registrar. "Disputes also help us to rewrite or tweak rules, because of trends identified," says Adams.

The hospital's March 2016 overall QA score was 98.94%. "Although that score seems pretty high, there were still 301 accounts or claims tracked through the QA tool that had errors and were not fixed within the 72-hour final bill cycle," says Adams. These claims had to be stopped and fixed before electronic billing could be completed. "Although that's a very small percentage of the total claims, the efficiency of the patient accounts team is negatively impacted," says Adams. Education on the front end is the department's primary focus for 2016.

"Depending on each provider's average claim size, those claims can then be translated into actual dollars or A/R [accounts receivable] days," says Adams. Patient access management teams are coaching front-end users as close to "live time," when the error was made, as possible, to prevent future errors.

"It is difficult to achieve 100% user attendance at monthly department meetings," says Adams. "The QA tool allows coaching of all users — in our case, approximately 100 users — live-time and daily."

Adams says of the QA tool, "There is no question that it improves accountability." Front-end users receive a daily worklist telling them what errors are counting against them that they need to fix.

"They are trained to fix errors live time when possible and, at a minimum, prior to end of shift," says Adams. *(See related story in this issue on how the tool's implementation affected billing processes.)* Users receive report cards that tell them their personal QA results, with a letter grade and percentage. The cards tell them how their scores compare to all hospital users. *[A sample report card used by the department is included with the online issue. For assistance accessing your online subscription, contact customer service at Customer.Service@AHCMedia.com or (800) 688-2421.]*

"They must review the report card with their Team Lead," says Adams. "We expect them to get a perfect 100% score."

This expectation of 100% is because the QA tool tells staff members exactly what errors to fix. "If they fix it, the error doesn't count against them. If they disagree with the error, they dispute it," says Adams.

If the reviewer agrees with the employee's reasoning, the error doesn't count against the employee. "If the reviewer disagrees, they reject the dispute, yet tell the user *why*," says Adams.

At Cottage Hospital in Woodsville, NH, registrars have 72 hours to correct errors identified by the department's QA tool (also AhiQA) before it affects their registration accuracy. **Jennifer A. White**, director of patient access, says, "It has increased the amount of clean claims and decreased finger pointing."

Registrars receive monthly report cards that they review, sign, and turn in to their director for their employee files. "The ability to create your own edits is beneficial, as payer requirements are ever-changing," says White.

The QA tool decreases the amount of time needed for training, because the edits and rules built into the tool decrease errors. "By the end of the first week, new hires are reviewing edits and making changes to their process," says White.

By the end of the second week, new hires are working independently. "They are confident that if they miss something, the tool will remind them," says White.

SOURCES

- Teresa Adams, CHAM, Patient Access Manager, Marion (IN) General Hospital. Phone: (765) 660-6161. Email: Teresa.Adams@mgh.net.
- Jennifer A. White, Director of Patient Access, Cottage Hospital, Woodsville, NH. Email: jawhite@cottagehospital.org. ■

Department Saw Worse QA Outcomes Initially

Marion (IN) General Hospital's patient access department saw worse quality assurance (QA) outcomes shortly after implementing a QA tool. However, this decrease was expected, because the quantity of data elements being final-reviewed was greatly increased.

"On a positive note, we had coached all users and departments that 'We can't fix it if we don't know it's a problem,'" says patient access manager **Teresa Adams**, CHAM.

The percentage of clean claims has increased, which has decreased accounts receivable days. Another advantage is that the patient accounts department can trust that claims are properly "scrubbed" due to rules in place that catch errors that will cause payer rejections. "Timeliness of claims transmissions is improved when staff aren't manually rechecking claims," says Adams.

The tool reduces many registration data elements that were being checked manually before billing was allowed to be transmitted. "They can now focus manual front-end efforts on payer challenges," says Adams. Billing staff are freed to fix difficult issues by working with payer representatives.

"Patient access collaborated with the back-end team of users to come up with rules that needed to be written," says Adams. For example, Medicaid ID numbers can be tricky to obtain from Indiana Anthem Healthy Indiana Plan (HIP). Only the payer can provide the ID number when patients present without an insurance card, as they often do.

The state of Indiana's electronic eligibility response only provides the 12-digit recipient ID number used by most Indiana Medicaid plans. Patient accounts billing experts trained patient access users on how to retrieve the actual Anthem HIP policy ID number.

"Patient access enter the patient's social security number as the policy ID number to prompt Anthem's response with their specific ID number format required for claims," says Adams. ■

'Zero Is Our Goal'— Dramatically Reduce Duplicate Medical Records

For patient access employees, wrong patient chosen is 'cardinal sin'

"Hi, I'm Anna Smith. My cardiologist told me to come in immediately because I'm having shortness of breath."

A registrar checking in this patient would have no way of knowing that the patient, who is clearly in distress, goes by her middle name — and also that she gave her maiden name because she's separated from her husband. In fact, the patient's legal name, under which the medical record is listed, is actually Maria Anna Garcia.

"Asking patients for their legal ID is critically important," says **Susan Sigler**, regional director of Patient Access West at Navigant Cymetrix, a Gardena, CA-based provider of revenue cycle management solutions.

If an overworked, distracted registrar simply enters the name provided by the patient, a duplicate medical record could be created. **Catherine M. Pallozzi,** CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital, says, "When staff members are busy, mistakes can happen."

The biggest worry with duplicate records is that patient safety will be compromised. "A wrong patient chosen in the EHR [electronic health record] is the 'cardinal sin.' The clinician must be able to trust the information being reviewed in the EHR is that of their patient," Pallozzi explains.

If the wrong patient is chosen, patient care decisions are made based on incorrect information. If there is a medical record duplicate, the patient care providers do not have the entire history of their patients. "The patient's information is residing under another medical record number," explains Pallozzi.

Possible solutions

Here are some possible solutions to decrease duplicate medical records in patient access areas:

• Patient access leaders can explain the importance of their role to clinical areas.

Clinicians are sometimes impatient with the check-in process, which includes matching the patient to the existing medical record. "Clinicians want to just receive the patient," says Sigler. "But clinicians should focus on the clinical."

Patient access can explain to clinical areas that registrars are the experts at matching the patient with the existing medical record, advises Sigler.

• Systems can give patients their own medical ID cards.

"It gives them a sense of belonging to your health system," says Sigler. "It also makes it very simple to ID them in any access point."

Albany Medical Center's patient

EXECUTIVE SUMMARY

Duplicate medical records potentially are dangerous to patients because care decisions are based on incorrect information. Albany Medical Center's patient access leaders use these strategies:

- holding registrars accountable for following Patient Look Up policies;
- researching every wrong patient chosen and medical record duplicate to determine underlying reasons;
- striving to eliminate avoidable duplicate medical records.

access leaders hold employees accountable for following this Patient Look Up policy:

• Registrars enter the first five letters of the patient's last name and first two letters of the first name.

• When the patient is identified, registrars must stop and ask the patient to provide the spelling of his or her name and date of birth.

"It must be methodical, and the staff member can't have the policy reviewed with them often enough," Pallozzi says. The department is looking into investing in technology to make this process easier for staff. "We are working with our vendor to embed patient photos in our ADT [admission, discharge, and transfer] system header," Pallozzi reports.

Every wrong patient chosen and medical record duplicate is researched by the hospital's Quality and Development department. "Medical record duplicates have become a focus of monitoring and follow up," says Pallozzi. Two things are determined:

• what the circumstances were that resulted in the wrong patient chosen;

• whether a wrong patient would have been selected if the appropriate policy were followed.

"Ninety-nine point nine percent of the time, had the correct protocol been followed, the wrong patient chosen or the medical record duplicate would *not* have resulted," says Pallozzi.

A recent analysis of a "wrong patient chosen" revealed a registrar's careless mistake. "Had the staff member stayed true to the expected two-step process, a wrong patient selection would not have resulted," says Pallozzi.

Instead of entering the first five letters of the patient's last name and first two letters of the patient's first name, the registrar entered the full last name and full first name. "This led to the wrong patient chosen, as they did not spell the entire name correctly," says Pallozzi. The registrar selected a patient with a similar name with a three-year difference in the date of birth. Since this mistake was the registrar's third similar mistake in a short period of time, a corrective action was issued.

Managers track each Wrong Patient Chosen and Medical Record Duplicate reason by staff member. This tracking is incorporated into employees' annual evaluations. "Depending on the number and reasons for Wrong Patient Chosen and Medical Record Duplicate, it impacts their overall quality rating and possibly their merit increase," says Pallozzi.

> "*ANY* AVOIDABLE WRONG PATIENT CHOSEN IS NOT GOOD."

Albany Medical Center's patient access managers report avoidable Wrong Patient Chosen and Medical Record Duplicates at unit monthly staff meetings and quarterly staff meetings. "*Any* avoidable wrong patient chosen is not good," says Pallozzi. "Keeping this number to only unavoidable reasons, such as incorrect information provided on a document, is a good first step."

The department has not yet reached that level on a monthly basis. "But we have seen months where we have had as few as three," Pallozzi says. "For an organization of our size, that is good. But zero is our goal."

In June 2015, patient access leaders at Bakersfield, CA-based Kern Medical rolled out a biometric tool that scans patients' fingerprints. (SafeChx, manufactured by Columbus, OH-based Cross Chx.) "This assists with encountering the correct patient information from the Master Patient Index," says **Edward Din**, director of patient access.

Duplicate records found

The tool has resulted in the identification of 5,201 duplicate medical records, with 4,975 resolved, as of the end of February 2016.

"Staff training is key," says Din. "Merely asking for the patient to provide you with their legal name and photo identification are not enough to protect patient medical information."

Patient access also developed policies, in collaboration with the health information management department and risk managers, to address identity theft and the safeguarding of patient information, says Din.

Patient access staff members explain to patients that the fingerprint scans protect their medical information. "The majority appear satisfied to know the hospital has taken the initiative to secure their information from being used by others," says Din.

SOURCES

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- Catherine M. Pallozzi, CHAM, CCS, Director, Patient Access, Albany (NY) Medical Center Hospital. Phone: (518) 262-3644. Email: PallozC@mail.amc.edu.
- Susan Sigler, Regional Director, Patient Access West, Navigant Cymetrix, Gardena, CA. Phone: (424) 201-6302. Email: Susan.Sigler@cymetrix.com. ■

Stanford Health Care's Patients Receive a 'One-Stop' Registration for the Hospital System

Patients offered single check-in for multiple same-day visits

Patient access leaders at Palo Alto, CA-based Stanford Health Care (SHC) recently overhauled the "status quo" of patient registration, reports **Anna Dapelo-Garcia**, MPA/HSA, administrative director of patient access services.

"Patient registration has remained relatively unchanged for many years, across hospital and ambulatory care settings," says Dapelo-Garcia. "It is a process patients expect as part of their healthcare journey."

From the patient's perspective, however, it can be time-consuming and repetitive. A "universal registration" system at Stanford allows patients to check in a single time for multiple same-day visits within the hospital system. This process includes clinic visits, radiology services, procedures, and/or laboratory services.

"This has decreased time spent on this function for patients by 70%," says Dapelo-Garcia. "For staff, we have realized a 57% reduction in registration time." This reduction is because one person can provide multiple registrations. "Patient registration has been transformed," says Dapelo-Garcia. "What was a common registration model for patients is radically different."

Bode K. Adeniyi, patient registration manager at the SHC Cancer Center South Bay in San Jose, CA, says the new registration system shows patients their time is valued. "We removed waste associated with a traditionally repetitive, complicated process," says Adeniyi. "All of this ultimately results in time being returned to the patient during their visit."

Shannon Jamarck, patient registration manager at the SHC Neuroscience Health Center in Palo Alto, notes that patients face many challenges in their day-to-day lives. "Mobility and memory are just a few struggles," says Jamarck. "This one-stop process gives them back control and ease. We have given them a little independence back into their lives."

The Stanford Health Care Neuroscience Health Center implemented the Patient Pass System in January 2016. This tool complements the health system's universal registration system. "This is cutting-edge technology," says Dapelo-Garcia. "Patients at this location are experiencing a registration process not utilized at any other healthcare facility." The Patient Pass System allows the patient to alert providers when the patient is ready for services. These steps occur:

1. Patients register at the central registration area for the day. "All registration requirements are validated in a single encounter," says Dapelo-Garcia.
2. Registrars give the patient a Patient Pass for each encounter, which includes the patient's name (truncated for patient privacy), appointment date and time, provider name, and bar code.
3. Patients scan the Patient Pass at a Patient Arrival Station, which is found in every service area.
4. Once the Patient Pass is scanned, the patient's visit is updated from "present" to "arrived." "This alerts the clinical team that the patient has arrived and is ready for service," says Dapelo-Garcia.

Patient Pass Arrival Stations are strategically placed to accommodate disabled patients. "On-screen messaging to patients is simple and intuitive," says Dapelo-Garcia. "Patient adoption rate has been in the 90th percentile."

Stanford Health Care's Patient Access Services department plans to use Universal Registration and the Patient Pass System in future medical building settings, as well as the new hospital facility in 2018.

"Patients have commented that they appreciate that they no longer have to stand in a registration line multiple times in one day," says Dapelo-Garcia.

EXECUTIVE SUMMARY

Patients at Stanford Health Care can check in a single time for multiple visits within the hospital system, which decreases time staff spend on registration by 57%.

- One person can provide multiple registrations.
- Patients spend 70% less time at registration.
- Providers are alerted when patients are ready for services.

SOURCE

- Anna Dapelo-Garcia, MPA/HSA, Patient Access Services, Stanford Health Care, Palo Alto, CA. Telephone: (650) 723-9292. ■

Auth in Place, Then Different Procedure Is Done? Avoid "No Auth" Claims Denials

EXECUTIVE SUMMARY

Payers may deny claims if a different procedure or additional procedure is done after the initial authorization was obtained. Patient access leaders at United Regional obtain 99.8% of all authorizations and use these strategies:

- obtaining authorization for a range of procedures or medications;
- asking payers to update the CPT codes on the authorization;
- contacting office managers if additional procedures often are done with a particular physician, so those CPT codes are included on future authorizations.

When a physician orders a procedure to be performed in a surgical setting at Birmingham, AL-based UAB Hospital, patient access staff start the process of obtaining required authorizations.

Once the physician begins the approved surgical procedure, however, there might be changes. "There are sometimes instances where the expected procedure to be performed has to be modified based on findings during the actual surgery," says patient access director **Lee Patillo**, CHAM.

Even with an effective upfront process, there are instances when a procedure that was not scheduled originally is added on after the patient arrives for service. **Amanda Taylor**, director of patient access at United Regional in Wichita Falls, TX, says, "Some examples where we see this occur most frequently include diagnostic studies, infusion medications, and surgical procedures," says Taylor.

Many insurances won't allow retroactive authorizations. This process means that the authorization has to be obtained prior to a service being performed. "This is an area that we have placed a lot of focus on," says Taylor. "We successfully obtain approximately 99.8% of all authorizations required."

Some payers allow a range of authorizations, while others will authorize only a single CPT code. "It is important to investigate this before the service is performed," says Taylor.

As soon as they're notified that additional procedures will be performed, patient access staff members begin working immediately to obtain required authorizations.

"Some insurance carriers allow us to contact them directly to update the CPT codes on the authorization," says Taylor. "Others require the physician to make those changes."

Patient access staff members can obtain authorizations only for services they are aware of, emphasizes Taylor. Here are some effective processes to avoid "no auth" claim denials:

• Diagnostic tests.

Diagnostic studies, such as CTs or MRIs, are the tests that change most frequently after being scheduled.

"This is normally due to a change in the contrast order," says Taylor. "To make the process work, we rely heavily on radiology [staff] to make us aware of changes prior to the test being performed."

These steps are taken:

— Patient access staff worked closely with radiology staff on the process.

— Patient access staff provided radiology with a list of payers that do not require authorizations.

"Radiology knows they do not need to reach out to us on those payers," says Taylor.

— Patient access staff provided the radiology staff with a direct contact on the hospital's insurance verification team to call when a change to a procedure occurs.

— Insurance verifiers review the procedure and the patient's insurance to determine the authorization requirements.

"We either inform the department that it is OK to proceed, or we ask that they give us time to obtain an authorization," says Taylor.

• Medications.

Patient access staff members have found that orders for medication infusions sometimes are substituted for different medications by the patient's physician. To avoid claims denials when this happens, "we

COMING IN FUTURE MONTHS

- Strategies to manage "difficult" colleagues
- Reduce costs of overtime and per diem staffing in access
- Fine-tune scripting used for upfront collections
- Respond to clinicians' complaints about registration delays

request an authorization for a range of medications to ensure, regardless of the medication provided, we will have the needed authorization in place," says Taylor.

• **Surgical procedures.**

"This is an area that we look at trending information," says Taylor. For example, patient access staff members sometimes notice that a particular physician frequently performs more than one procedure, even if only one procedure was scheduled.

"In those instances, it is best to look at specific detail, such as the type of procedures and how frequently it occurs," says Taylor. Next, patient access staff members work with the physician's office to develop a plan. "We reach out to the office manager and gain a better understanding of why we are frequently seeing changes," says Taylor. In some cases, the additional CPT codes can be included in future authorizations upfront. "It takes a multidisciplinary approach to effectively manage denials due to lack of authorization," emphasizes Taylor.

At UAB Hospital, utilization managers work with payers to obtain authorizations for any additional procedures that are performed. "Once the updated authorization is obtained, the utilization manager updates the authorization in the hospital billing system," says Patillo. "This prevents a denial." ■

Can Yelp Reviews Enhance Reports on Hospital Quality?

Yelp reviews of hospitals cover topics not found in the federal government's survey of patients' hospital experiences, according to the results of a study from Perelman School of Medicine researchers at the University of Pennsylvania in Philadelphia.

The study is published in the April issue of *Health Affairs*. *(Readers can access the abstract by going to http://bit.ly/1MAt5rN.)*

Researchers compared about 17,000 Yelp reviews of 1,352 hospitals to reviews from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

While the Yelp reviews included information about seven of the 11 HCAHPS domains, the researchers uncovered 12 more categories covered in the Yelp reviews that are not covered by the HCAHPS survey: cost of hospital visit, insurance and billing, ancillary testing, facilities, amenities, scheduling, compassion of staff, family member care, quality of nursing, quality of staff, quality of technical aspects of care, and specific type of medical care. Two of the top five Yelp categories most strongly associated with negative Yelp review ratings were insurance and billing, and cost of hospital visit. Cost is not covered by HCAHPS domains. ■

Next Month: Employee Retention

The July 2016 *Hospital Access Management* will be a special issue on retention in patient access. We'll give strategies for offering opportunities to advance, encouraging employees to obtain CHAM certification, and getting pay increases approved for employees. ■

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SAMPLE QA REPORT

Once the report has generated, there is the option of drilling down the report to include the data for one user. For instance, see the image below on the Report Card Summary Report. By clicking on the username hyperlink DuckN1. The report will drill down and run the data only for Duck, Nicole.

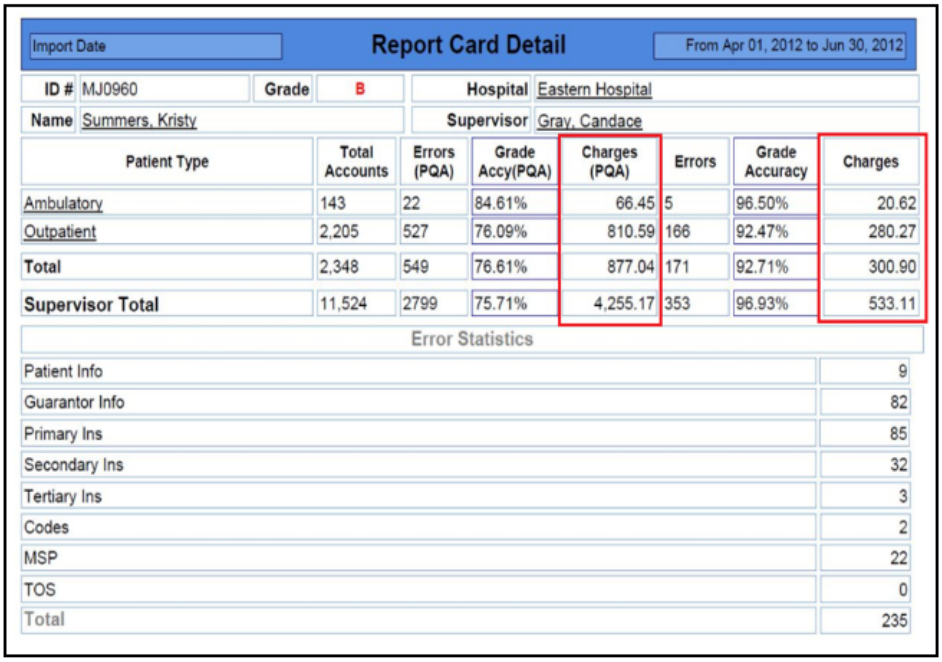
Import Date, Active Employees only

Report Card Summary

From Apr 01, 2012 to Jun 30, 2012

ID #	Name	Grade	Total Accts	Errors (PQA)	Grade Accy(PQA)	Charges (PQA)	Errors	Grade Accuracy	Charges
Hospital	Eastern Hospital								
CaseE1	Gray, Candace								
DuckN1	Duck, Nicole	A	1,703	378	77.80%	580.60	3	99.82%	20.56
DO3925	Durilla, Toni	A	1,569	418	73.35%	543.18	2	99.87%	3.25
AANAW0	Farrell, April	A	1	0	100.00%	0.00	0	100.00%	0.00
CaseE1	Gray, Nicole	A	348	87	75.00%	183.34	6	98.27%	0.00
JONEJC	Koscicki, Erin	B	323	69	78.63%	175.93	36	88.85%	53.57
CF5977	Meyer,Tammy	A	2,325	417	82.06%	647.66	38	98.36%	63.04
HUTSJ1	Schade, David	F	23	11	52.17%	0.00	11	52.17%	0.00
AANIP0	Schutte, Amy	B	8	0	100.00%	0.00	1	87.50%	0.00
ARRIN2	Scott, Tammy	A	1,517	450	70.33%	552.74	67	95.58%	49.21
DS9553	Shaw, Toni	A	118	17	85.59%	18.17	3	97.45%	0.00
MJ0960	Summers,Amy	B	2,348	549	76.61%	877.04	171	92.71%	300.90
TR3564	Taylor, April	A	788	223	71.70%	544.80	8	98.98%	40.54
GERMB1	Thompson, Er	A	453	180	60.26%	131.70	7	98.45%	2.04
Supervisor Total		A	11,524	2799	75.71%	4,255.17	353	96.93%	533.11
Hospital Total		A	23,770	5351	77.48%	7,973.68	801	96.63%	1,353.69

From the Report Card Detail report; to drill up to the Report Card Summary again which will include all staff on a supervisor's team click on the Report Card Summary hyperlink above the generated report.



Import Date | **Report Card Detail** | From Apr 01, 2012 to Jun 30, 2012

ID #	MJ0960	Grade	B	Hospital	Eastern Hospital	
Name	Summers, Kristy			Supervisor	Gray, Candace	

Patient Type	Total Accounts	Errors (PQA)	Grade Accy(PQA)	Charges (PQA)	Errors	Grade Accuracy	Charges
Ambulatory	143	22	84.61%	66.45	5	96.50%	20.62
Outpatient	2,205	527	76.09%	810.59	166	92.47%	280.27
Total	2,348	549	76.61%	877.04	171	92.71%	300.90
Supervisor Total	11,524	2799	75.71%	4,255.17	353	96.93%	533.11

Error Statistics

Patient Info	9
Guarantor Info	82
Primary Ins	85
Secondary Ins	32
Tertiary Ins	3
Codes	2
MSP	22
TOS	0
Total	235

Source: Marion (IN) General Hospital.