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INSIDE

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Patient Access Roles Are Highly Complex, But Pay Is Entry Level

Trend is to 'push all the complexity to the front end'

Patient access is asked to carry out more duties than ever, but many departments struggle with retention due to outdated entry-level pay.

"You need data to show why the positions are worth more," says **Rebecca Haymaker**, director of registration and technical Services at UW Health in Madison, WI.

"YOU NEED DATA TO SHOW WHY THE POSITIONS ARE WORTH MORE." — REBECCA HAYMAKER, UW HEALTH

UW's revenue cycle department recently tackled this problem in a comprehensive way.

"Certainly, patient access had the most to gain, but it wasn't a patient access-driven initiative. It was a revenue cycle initiative," Haymaker says.

The revenue cycle has changed dramatically in recent years.

"Patient access has a huge impact on the hospital's bottom line," Haymaker says.

Previously, the more complex, analytical work was performed by the business office, but automated payment postings and claims submissions have made the "back end" jobs easier. The front end, on the other hand, has morphed from largely clerical, data-entry duties into a complex role encompassing financial counseling and price estimation.

However, pay scales didn't reflect these changes.

"Not only was there a disparity on the front end, but there had also been changes on the back end," Haymaker notes.

Many of UW Health's traditional back end functions had moved to the front end, including collections, financial counseling, claim edits, and denials management.

The "patient experience," encompassing the patient's financial experience and overall satisfaction, is a top priority for the entire organization, and patient access staff play a major role.

"If this is really our number

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one priority, then we need to compensate like it's our number one priority," Haymaker adds. "We needed to 'right size' our revenue cycle to reflect the work that's actually done today, not what's been done historically."

Not an Easy Process

UW's project entailed looking at the responsibilities of all 19 roles, and more than 30 job titles, in the revenue cycle to determine what compensation is appropriate.

"This isn't an easy process by any means. It took us about two years to complete," Haymaker explains.

Patient access first convinced HR leadership to come on board. "We created a position review document," Haymaker recalls. Using standard methodology, all compensable factors were weighted. These included required experience, decision-making, required knowledge, patient interaction, and customer service.

"We went through every single position, and gave it a [score of] 1 to 5 for each compensable factor," Haymaker says. "We gave the highest weight to customer service."

Registration roles didn't necessarily require any experience, for instance, but transplant financial counselors did.

"We came up with a total score for each position," Haymaker notes.

The next step was to conduct a market analysis. "This is where we hit a snag," she says. Most organizations haven't gone through the same process, so there wasn't data to support the proposed pay scale.

"HR took our proposed titles and position descriptions, and queried other healthcare organizations," Haymaker explains.

Other organizations were asked to submit confidential compensation information for comparable positions.

"Not every role is comparable with other organizations, so you need to pick your most common titles," Haymaker says.

Even then, responsibilities vary greatly depending on the organization.

The compensation information that came back wasn't helpful, since it aligned with the traditional way of grading the positions.

"Because there are not many organizations that have reviewed their revenue cycle positions as a whole, we felt as though we were not going to align with pay for our patient access and customer service positions," Haymaker says.

Not Lowest Paid

Undeterred by the setback, UW Health's patient access leaders argued strongly for more compensation.

"We made a case that certain roles should be compensated differently than the fair market value," Haymaker says. "It was uncomfortable at times, but it was a good exercise to go through."

Ultimately, the group succeeded in getting pay upgrades for most patient access positions.

"At the end of the day, registration isn't at the top of our pay grade, but they are not the lowest anymore," Haymaker says. "They are at least on par with their counterparts in the business office."

Previously, patient access employees often left the department for better-paid positions with the business office.

"It was a pay increase, with more

flexibility, and perks like wearing jeans," Haymaker notes. "We were constantly losing people."

Some back-end billing positions decreased in pay grade because of the initiative (current employees continued at their present rate, so no pay cut was given). For patient access, this meant improved retention.

"We went almost a full year without any turnover in outpatient registration, which was unheard of," Haymaker recalls.

More candidates for patient access jobs have college degrees.

"We are also holding people accountable," Haymaker says.

The department created stricter guidelines for staff to move to higher-level positions.

Recent integration of the health system has put patient access compensation in flux once again. The size of patient access increased because of multiple new locations, necessitating repeating the process.

Previously, the medical foundation and hospital and clinics operated as separate organizers and employers.

"We integrated under one UW Health umbrella in the summer of 2015," Haymaker says.

Throughout the organization, all positions are under review to achieve equal compensation for equal roles.

"Today, the hospital registrars are paid differently than our medical foundation registrars," Haymaker says.

To align staff into the same job titles, HR will conduct a current market compensation study again.

"We anticipate we're going to hit that same challenge with the front-end staff again when we do those market comparisons," Haymaker says.

Since cash collections previously were conducted on the "back end," the most highly skilled and qualified people usually were placed in the business office — with commensurate compensation. However, this has changed dramatically, with patient access handling comprehensive pre-service financial clearance.

EXECUTIVE SUMMARY

Patient access departments struggle with obtaining pay increases for employees, despite a greatly expanded role. Some results of UW Health's initiative:

- Most patient access staff received pay increases.
- Some billing positions decreased in pay grade.
- Outpatient registration went a year without any turnover.

PATEL NOTES THAT PATIENT ACCESS LEADERS MUST "JUSTIFY APPROPRIATE PAY INCREASES TO ATTRACT AND RETAIN THE RIGHT TALENT TO PATIENT ACCESS."

"In the new revenue cycle world, the goal is to push all the complexity to the front," says **Ketan Patel**, a senior manager in the healthcare provider segment of strategy and operations for New York City-based Deloitte Consulting. "Get it right the first time" is the goal.

"This makes the business office simply an exception-based processing center," Patel adds.

Conversely, in patient access, higher compensation is needed. Patel notes that patient access leaders must "justify appropriate pay increases to attract and retain the right talent to patient access."

Susan Labow, vice president of Long Beach, CA-based Receivables Optimization Incorporated, and former interim executive director of revenue cycle at Bakersfield, CA-based Kern Medical Center, recently conducted a revenue cycle assessment at a mid-sized hospital. She asked hospital administration what kind of education was provided to patient access staff.

"I said, 'I am willing to bet that the people managing the stock portfolio for your board members have more than a GED or high school degree. Yet, you have patient access staff making million-dollar decisions every day,'" Labow recalls.

If patient access staff select the wrong payer, significant amounts of revenue are at stake.

"These people are the first line of defense and are paid the least," Labow says.

Patient access employees are the first people the public sees, and they interact constantly with clinicians and patients.

"Patient access must know all the rules for all the payers in all situations, all the time," Labow adds. "The hospital's most experienced collector doesn't have this knowledge." ■

SOURCES

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Outdated Job Descriptions Obstacle to Patient Access Pay Increases

There are many inaccurate details about the day-to-day duties of front-end staff

When **Heather Bent** sent patient access job descriptions for a market analysis for the first time in six years, she didn't get the results she was hoping for. "Nothing came back," she says. "We found out that some of the responsibilities we listed, such as clerical duties, couldn't be quantified."

The job descriptions were "completely outdated and very vague," says Bent, a patient access senior manager at Florida Hospital East Orlando.

Meanwhile, patient access fielded a steady stream of complaints from employees who thought their pay didn't reflect all the new tasks they were expected to perform. Some left the department for higher-paying positions, either at the hospital or outside the organization.

It became clear the outdated job descriptions were the main obstacle to approving pay increases. **Marta Simons**, a patient access manager at Florida Hospital East Orlando, explains, "They didn't truly describe what a person had to do on a daily basis." The job description for registration representative gave "maintains account accuracy" as an expectation, for instance. "But it didn't say what the employee was expected to do for the account to be sure it's accurate," Simons adds.

Better Analysis Needed

Bent and a patient access director rewrote 10 job descriptions. "We then came back together as a team for the four hospitals. All patient ac-

Don't Set False Expectation for New Patient Hires

Outdated job descriptions set a false expectation for new patient access hires, warns **Stacy Hutchison-Neale**, CRCR, CHAA, supervisor of the hospital pre-authorization department at Wilmington, DE-based Nemours Alfred I. DuPont Hospital for Children.

Accurate job descriptions "would help associates understand that they are not just answering phones and scheduling appointments," Hutchison-Neale argues.

People applying for registrar positions might learn that the job includes collecting from patients, for instance — something that is not comfortable for everyone. "It may deter them from applying for a position that does not meet their expectations," Hutchison-Neale says.

Other applicants don't realize they'll need to make a family aware of their out-of-pocket costs or explain insurance coverage and benefits. "I hear quite often that anything pertaining to the insurance is the patient's responsibility," Hutchison-Neale says.

Similarly, applicants often assume they don't have to know specifics about a patient's insurance to determine if the coverage is active. "Assisting a family and knowing about insurance companies and patient responsibility is everyone's responsibility," Hutchison-Neale underscores.

Patient access leaders are trying to create ways to ensure the department's job descriptions are updated on a regular basis to clearly reflect changing requirements. "Currently, managers and supervisors are notified when mandatory training is needed," Hutchison-Neale notes. "It would be great to have notifications for annual review of job descriptions." ■

SOURCE

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cess directors met and agreed on the changes," she says. The revised job descriptions were submitted and are awaiting approval.

"Meanwhile, we went to HR and asked for recommendations for how we can get a better market analysis," Bent says.

Bent learned that the first four bullet points become the main focus of the analysis, but the department's job descriptions listed eight. Expectations were listed in the order they occurred, instead of their importance.

"So all the descriptions listed 'Greeting' as the first thing. Obviously, you don't need to pay people very much to greet people," Bent explains. "We don't want that to be what they are comparing us to in the market."

Another tip from HR: Use different bullet points for lead registration representatives to reflect a focus on team metrics instead of individual metrics.

It was particularly difficult to convey the complexity of the ED registrar role. "It was challenging to communicate just how stressful it can get, and how multitasking plays a big role in this position," Simons explains.

Another challenge was that patient access had to make its job descriptions consistent across nine hospital campuses. Each campus functions somewhat differently because of varying volumes. "But we are all using the same job description," Bent notes. "That was very challenging."

USE DIFFERENT BULLET POINTS FOR LEAD REGISTRATION REPRESENTATIVES TO REFLECT A FOCUS ON TEAM METRICS INSTEAD OF INDIVIDUAL METRICS.

The busiest ED sees more than 400 patients a day, but lists the same job description as a much smaller ED that sees only 60 patients a day, for instance. In addition, there are different expectations for outpatient and ED registrars but were combined into a single job description. This allows outpatient registrars to cover the ED as needed, since the same skill sets are required. "With the new job description, if we don't have the volume in outpatient, we can float them over [to] the ED," Bent says.

Even patient access leadership job descriptions needed an update. "They were outdated and somewhat inaccurate," Bent adds. "We expect a lot more from our leaders than we had on paper."

Employees remain well informed while anxiously awaiting their hoped-for pay increases. "They were the ones who voiced concerns from the beginning," Simons notes. "We want to retain them and are keeping them engaged in other ways."

Patient access staff are encouraged to participate in hospital committees, for instance, and are offered monetary incentives if collection goals are met. "We know pay is a hot topic for them," Bent says. "We are trying to give them some additional compensation while we're waiting for approval." ■

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Registrar No Longer Job for Just Anyone

Right kind of person needed for patient access

The skill set needed to keep up with new processes and technology in patient access has changed — and so is the type of person who is right for a registrar role.

"Hiring 'just anyone' for registration, because of a belief that it's an area that doesn't need excellent people with great coping skills and intelligence, will doom a department," says **T.T. "Mitch" Mitchell**, president of T.T. Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology.

Detail-oriented, tech-savvy people are a better bet as registrars. "Hiring people who can work better and smarter is needed, since most billing systems are upfront," Mitchell explains. "If the information is good,

the bills go out quicker."

Mitchell urges hiring managers to put aside thoughts about the type of people patient access has hired in the past. Instead, consider the type of person that can help a department meet short-term and long-term goals.

"Hiring the right people ahead of time means their recommendations will be invaluable to modernizing the process as time goes on," Mitchell adds.

Christa Kendall, admissions services supervisor for patient registration at Springfield, MO-based CoxHealth, always looks for customer service skills first. "Empathy, understanding, and communications — these attributes not only help in patient care, but promote a cohesive work environment," she says.

One candidate was very experienced in the department's software programs, came from a medical background, and presented a great resume — but visibly cringed when discussing contact with patients. "On the other hand, I have had candidates with little job history, but who turned out to have an open attitude and personal drive perfectly suited to the position," Kendall says.

Heather Bent, a patient access senior manager at Florida Hospital East Orlando, considers the setting in which the registrar will work. The ED and outpatient areas are very different.

Someone who has worked at a restaurant is used to standing, for instance, whereas someone who has worked a desk job is probably more sedentary. Bent is clear with applicants for ED registrar positions about what to expect. "I tell them, 'There is really no down time in the ED. You are up and mobile. There is no 'sit down and register someone' time — you are standing up when you do it.'"

Upon hearing this, some applicants look very nervous and hesitant. Others appear excited. "We are not really looking for someone who says, 'I don't mind doing that,'" Bent says. "We want someone who says, 'Oh, that sounds awesome.'" ■

EXECUTIVE SUMMARY

The skill set for patient access employees has changed dramatically in recent years, and hiring managers must make decisions accordingly. To make smarter choices:

- choose detail-oriented, tech-savvy applicants;
- observe how applicants react to learning there is no down time;
- consider applicants with good customer service skills, even if their experience is limited.

SOURCES

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Surprise Medical Bills Root of Many Complaints

It sometimes takes weeks to find out what occurred

When a patient at Salt Lake City-based Huntsman Cancer Hospital received an unexpected bill for $6,500, he filed a complaint with the hospital's customer service and risk management team. "The hospital bill was way more than what he was initially quoted," says **Junko I. Fowles**, CHAA, supervisor of patient access and financial counseling in the division of revenue cycle support services.

The patient had been quoted $250 for a new patient pathology over-read, as per the hospital's policy. "And that was exactly what was ordered by an attending physician," Fowles says. It turned out that the pathologist who interpreted the materials had ordered molecular testing to confirm the diagnosis. "This was happening behind the scenes," Fowles explains. "Nobody, including the ordering physician's office or financial counselors, was notified of such expensive tests being ordered."

The patient was not made aware the testing was ordered, either. "He certainly had no idea what his out of pocket would have been. Otherwise, he would not have consented," Fowles notes.

It took more than two weeks for the department to figure out the root cause of the issue. First, the department contacted outpatient coding to see if there was an incorrect charge posting. Then, the department contacted the claims follow-up team, the

laboratory, financial counseling, the referring physician's office, the attending physician's office, and pathology.

"The change we've made from this experience is to have the pathologist team notify us before ordering expensive molecular testing," Fowles says. This way, the patient learns about possible high out-of-pocket costs.

Revenue cycle leaders are looking into automating the process. Any molecular testing orders placed in the system would flag the attending physician's office, financial counselors, and the prior authorization team.

The team still had to address the individual patient's concern. "We contacted the patient and explained what had happened," Fowles says. Staff told the patient that since these were billable charges, the hospital still would bill his insurance, but would adjust his liability accordingly.

Another common complaint at Huntsman also involves surprise bills. Some patients learned that their insurance was out of network with the hospital only after the completion of a service. This scenario happens more often because of payers' "narrow" networks. "It's becoming such a challenge to know what plans and payers are accepted by our facility and providers," Fowles says.

Many out-of-network patients cannot afford their out-of-pocket costs. "It would end up in hospital charity write-offs and bad debt," Fowles notes. To improve communication with patients and reduce write-off amounts, the department took these steps:

- The department created a work queue to capture out-of-network plans;
- Financial counselors notify patients that they're out of network prior to the date of service;
- Supervisors provide ongoing training to front-end staff on how to identify out-of-network plans.

"We share payer updates from the contracting team with the front-end users," Fowles adds. ■

SOURCE

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Is Registrar Bad Fit? Act Before Morale Plummets

Holding off on termination isn't always best

A registrar constantly came to work with a bad attitude at the University of Tennessee Medical Center in Knoxville. "She was very disengaged and started having a pattern of unscheduled time off," recalls patient access manager **Michelle Reno**.

The registrar was a long-term hospital employee who had recently transferred internally to patient access. Even after coaching and corrective action, her attendance continued to be a problem. Eventually, the employee was fired.

With the problem employee gone, "the team had better morale, and was even OK working short-staffed," Reno says. The lesson for patient access: Failing to act if employees aren't meeting expectations can cause others to become disengaged. "During the first coaching session, there need to be clear consequences so there aren't any surprises," Reno advises.

At Texas Health Harris Methodist Hospital Southwest Fort Worth, a registrar missed work constantly. A patient access manager warned her for many months before finally considering termination. "After meeting with human resources, they determined that disciplinary action taken by the manager should have come sooner. Too many opportunities were granted," says **Laura Rasor**, director of patient access services. After the employee was terminated, the manager learned about expectations for timely action.

"Terminating is never the ideal option," Rasor says. "But with patient satisfaction and financial sustainability as our main focus,

EXECUTIVE SUMMARY

Failing to take action with a problem patient access employee can hurt morale in the department. If terminating an employee is a possibility:

- ensure employee has received sufficient training;
- give clear timeframes for expectations;
- schedule frequent status meetings;
- consider if another role is a better fit.

sometimes it is the only option."

Best Chance at Success

Timely feedback to staff is essential. "We do this so they are aware of their performance status," Rasor explains. "They have an opportunity to improve moving forward." Managers meet with their employees monthly to review "scorecards," which cover productivity, point-of-service collections, quality assurance scores, and usage of required tools and programs.

"When the expectations are not met or improved upon after a certain period of time, corrective action and/or termination of employment is something that must be considered," Rasor concludes. She advises patient access leaders to ask two questions if they're considering terminating someone:

1. Has the employee adequately been made aware of his or her errors or opportunities, and have those efforts been documented?

2. Has the employee been appropriately trained and/or offered ample refresher training?

"We have an obligation to provide every employee with the very best chances at success," Rasor says. "If we don't do that, then it is my opinion that their failure is our failure."

Not for Everyone

Patient access isn't for everyone. "What used to be an entry-level position now requires some pretty savvy computer skills, with the ability to work in many applications at once," says **Jill Pfeifer**, revenue cycle educator at Springfield, MO-based CoxHealth.

> TOP-NOTCH CUSTOMER SERVICE SKILLS HAVE BECOME AN ESSENTIAL PART OF THE JOB. HOWEVER, THIS ISN'T A STRENGTH FOR EVERYONE.

Top-notch customer service skills have become an essential part of the job. However, this isn't a strength for everyone. "Working with patients takes a special kind of person, especially when exceptional customer service is expected with every interaction," Pfeifer notes.

It's possible that sufficient training and feedback can turn things around. "You can't improve if you don't know you're doing it wrong," Pfeifer says.

Another possibility is that the disengaged employee just needs to play a different role to thrive. "Maybe we have a good employee that just can't do this job," Pfeifer offers. "We always need to ask, 'Are you on the right bus, [but] just in the wrong seat?'"

When Pfeifer deals with employee issues, she schedules frequent status meetings. This way, the decision to terminate isn't dragged out over a long period. This approach results in one of two things, she says: "An improved employee — or a timely termination." ■

SOURCES

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'Medical Necessity' Denials Surging; Clinical Information Required

Payers want documentation to avoid denial

Some patient access departments see a surge in claims denials due to "medical necessity," with payers claiming the service wasn't medically necessary. "We are seeing the large plans beginning to be more stringent with their guidelines, causing an increase in the medical necessity denials," reports **Heather Nieto**, director of patient access at the University of Chicago Medicine.

Most denied claims are for infusions and unplanned surgical admissions. "In our authorization process, we attempt to obtain prede-

terminations in addition to precertifications," Nieto explains. This is required specifically for all off-label use infusions and procedures. "This is a bit more cumbersome, because predeterminations cannot be completed online," Nieto notes. "They must be called in."

This poses a staffing issue, since the prior authorization team handles authorizations online, not time-consuming phone calls. A motivating factor: Payers often ask for a peer-to-peer review with the physician, if the necessary clinical data isn't submitted at the onset. "We do everything we can to avoid this," Nieto says.

As for clinical documentation, registrars can obtain it directly from the EMR, which, at a minimum, includes the last history and physical, the last visit clinic notes, and any testing that has taken place prior to the requested service. Registrars print whatever is required, then fax, scan, or email it directly to payers.

"If there are not sufficient clinicals in the EMR, we contact the specific clinic to get the necessary data and submit it," Nieto explains. "Our goal is always to have a midlevel provider or nurse to contact." ■

EXECUTIVE SUMMARY

Payers ask for additional clinical documentation to demonstrate medical necessity before paying claims. Registrars at the University of Chicago Medicine take these steps:

- Ask registrars to call to obtain pre-determinations;
- Obtain clinical documentation directly from the EMR;
- Contact clinics to retrieve missing information.

SOURCE

- **Heather Nieto**, Director, Patient Access, The University of Chicago Medicine. Phone: (773) 702-3872. Fax: (773) 926-0712. Email: Heather.Nieto@uchospitals.edu.

Surprising Data on Unique Patient Identifiers

Experts recommend patient access departments fine-tune processes

A new study on patient idenfiers surprised researchers in two ways. "First, an individual's first name, last name, and date of birth is actually a fairly unique identifier," says **John Zech**, the study's lead author who works at the Icahn School of Medicine at Mount Sinai in New York City.[1]

The researchers analyzed a large Social Security database of 85.8 million individuals. Any given individual had a 98.81% chance of having a unique combination of first name, last name, and date of birth that they shared with no one else in the group.

The second surprise was that a large health information exchange (HIE) with approximately 11.6 million patients did not link many records with the same first name, last name, and date of birth.

In the Social Security database, an average of 1.0062 people shared each unique first name, last name, and date of birth. In HIE data, despite dealing with a significantly smaller population, that number was 1.1238.

"That means the HIE probably was not connecting records that belonged to the same patients, because those records had different data in other fields, such as address or phone number," Zech says.

Improve Match Rates

Given that nearly 99% of individuals in a database of 85 million have a unique first name, last name, and date of birth in data sets with a smaller number of individuals (such as a hospital's master patient index), one could expect it to be very rare for two different individuals to share the same first name, last name, and date of birth, Zech explains.

"Registration departments should try their very best to accurately obtain a patient's correct legal name and date of birth," he underscores. "It is important for matching patient records."

Database engineers at hospitals should question their record-matching process if it gives a result in which many records with identical names and dates of birth are split across different patients. "They can use a calculation we give in the paper to check their matching process from this perspective," Zech suggests.

If a hospital has a large percentage of records that share first name, last name, and date of birth, that might indicate they need to put in place a program to improve their match rates. This can be done by fine-tuning matching algorithms, manual processes, or both.

It can be difficult for registrars

to find time to verify the spelling of a patient's name or to check if an address on file has changed. "If these items are out of sync, however, patient records may not be correctly matched," Zech warns.

Single Medical Record

To achieve the goal of a single medical record for every person, it is necessary to create a universal patient identifier. "No attempt to match records on demographic data collected at the point of care — no matter how carefully done — will be able to avoid some false-positive and false-negative links," Zech says.

However, it is not clear that Americans currently want a single medical record for each patient. "Many have concerns about privacy," Zech notes.

Federal law currently prohibits the use of federal funding to develop a universal patient identifier. "Until patients come to appreciate the benefits of a single medical record — and advocate for it politically — we will have to improvise as best we can to maintain and match patients' records with the imperfect data we have available," Zech says. ■

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SOURCE

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Long Wait Without Explanation? It's 'Breaking Point' for Many

Constant communication between staff and patients eases tension

Waiting with no idea what's going on "is the breaking point for many patients," according **Donna J. Roettger**, CHAA, director of access services education and training at Hackensack Meridian Health in Tinton Falls, NJ.

"Coming to the hospital is usually riddled with a lot of unknowns, and this can be overwhelming," Roettger notes. Many patients don't know what's causing their symptoms, whether their problem is serious, or whether their insurance will cover the cost of services.

Although patient access can't answer all the patient's questions, they can keep patients fully informed during their wait time. "Waiting without being informed about what is going on can upset patients and cause unnecessary grief," Roettger warns.

Explain All Holdups

Many different glitches can occur at check-in, delaying patients. "Staff may find out that the service requires an authorization. Or maybe the physician order was not sent, which can be a common struggle in patient access," says **Kim Rice**, MHA, director of patient access at Shasta Regional Medical Center in Redding, CA.

Patient access staff work closely with the patient on each step in the process. "Often, things can be time consuming," Rice says. "Staff provide ongoing updates to the patient while they wait in the lobby." Patient access offer a meal ticket if the wait is unexpectedly long. "Usually, a gesture of kindness goes a long way," Rice notes.

Patient access uses the same "constant communication" approach with clinical staff. "We make them aware there is a holdup keeping the patient in registration longer than anticipated," Rice explains.

Keep in Touch

Just keeping in touch with patients can defuse simmering ten-

EXECUTIVE SUMMARY

Constant communication with patients waiting in registration areas has significantly improved satisfaction at Hackensack Meridian Health. Patient access employees tell patients:

- if a prescription, authorization, or referral is missing;
- if the physician order was not sent;
- that a call was made to the doctor's office or insurance company.

sion. "If a patient asks if they can have something to drink, we ask the nurse, then return to the patient with the answer," Roettger says.

"How long am I going to wait?" is not always easy to answer. Missing prescriptions, authorizations, or referrals often cause the delay. "We often rely on other departments to perform exams or tests, or wait for doctor's offices to send the required information," Roettger explains.

When registrars are checking in a patient during a busy time, they're careful not to specify how long the wait will be. Instead, they say, "We are presently experiencing a high volume, but we will get to you as soon as possible." Instead of saying, "Someone will call you in a few minutes," they say, "The tech will call you as soon as they are ready for you."

In the ED, registrars say, "We've had a number of critical patients come in who need to be taken care of right away. I apologize for the wait, but someone will be with you as soon as possible."

Like recordings used by companies to break up the hold time on phone calls, checking in with patients breaks up the wait. "Just peeking into a room with a friendly, 'How are you doing? Can I get you a blanket?' creates a connection," Roettger says.

In the outpatient department, prescriptions often are missing a diagnosis, date, or doctor's signature, or a patient may need a referral or authorization. This usually means registrars must call a doctor's office or insurance company.

"The patient will sit and wait for the doctor or insurance company to get back to us," Roettger explains. "If offices forget to send what they said they would, we have to call back and remind them."

Patients don't like to be kept guessing, so registrars make a point of telling them the call was made. "This not only resets that 'wait-time clock,' but the patients also feel like they have an ally," Roettger says. "This distracts them from what often seems like an endless wait."

Stress and anxiety go hand in hand with hospital visits and can't be avoided. "But it can be alleviated — by registrars who are willing to take the extra step to keep patients in the loop," Roettger says. ■

SOURCES

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Tips for Keeping Waiting Patients Happy

Here are some ways patient access departments keep patients happy while waiting in registration areas:

• Staff use scripting to manage patients' expectations.

When ED patients arrive at Cape Coral (FL) Hospital, registration staff tell them: "I want you to know how things work, so you'll know what to expect. We take care of many people. Even though we prefer you not to wait, it's very hard. Some patients need more care than others."

ED registrars also explain the delay with the customer's perspective in mind, by stating, "Other patients are taking longer than we predicted. Our care team wants to give each person the time needed."

"We empathize with them that we know it can be hard to wait when they aren't feeling well or have other things to do," says **Jill Andreasen**, CHAM, director of registration and patient business services.

• Registrars apologize, when appropriate.

If a problem with an order or authorization arises, registrars explain the problem. Then they add: "Mr. Smith/Sir, I'm so sorry we haven't been able to take you yet. I want you to know we haven't forgotten about you."

Jazzmin Graves, lead patient access registrar in the outpatient department at Northwest Hospital in Randallstown, MD, says, "an apology goes a long way. We explain that something unexpected happened, and that we are sorry to inconvenience them."

• Registrars keep families informed while their loved ones are undergoing surgery.

"Because patients sometimes have to arrive two hours before surgery, their family members are waiting for a very long time," Graves says.

At Northwest Hospital, a "surgi-board" is in a patient waiting area. Patients receive a unique number when they register. "As they move through the surgery process, their family members can track them on the surgi-board with their numbers," Graves says.

The number is in green if the patient is in pre-op, coral if the patient

is in the operating room, and blue once the patient is in recovery.

• Registrars give vouchers to families.

If family members had a long day of waiting, registrars offer vouchers for the cafeteria and gift shop. "Even though it is just a small way to show them we care, they tell me that it makes them feel good that we make the effort," Graves notes.

• Patient access staff walk through the lobby.

"Staff are to keep an eye on patients who are waiting," says **Tanya Powell**, CHAM, patient access director for Ochsner Healthcare's Northshore Region in Slidell, LA. The expectation is for the supervisor or patient access lead to walk the lobby at least once every 30 minutes.

• Staff "handoff" at the end of their shift.

"Before an employee goes on break or to lunch, they have to do a handoff so no one is forgotten," Powell says.

The evening staff registrar comes on at 4:30 p.m., and gets a rundown of who is waiting, and for what.

• Registrars text waiting patients.

Ochsner's ED registrars can send patients text messages while they're waiting to keep them informed about tests ordered and bed availability.

• Registrars keep patients in view.

Baltimore-based Mercy Medical Center's admitting office features a large window.

"We can see the patients, and they can readily see us," says **Betty Bopst**, CHAM, director of patient access. "We talk with them often, and offer comfort measures."

If the patient is observed covering themselves with a coat, registrars come out and offer a warm blanket — and food and drink, if approved by the patient's physician.

Sometimes a patient appears anxious; if so, the nursing office is just a few steps away.

"If we call them, they come right over to offer reassurance and assistance," Bopst says. ■

SOURCES

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