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INSIDE

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Cut A/R Days by 15% in 1 Year: Move Back-end Functions to Patient Access

Boost revenue by taking on billing office tasks

When patient access took on the back-end functions at Abington-Jefferson Health (PA), accounts receivable (A/R) days were cut by 15% in one year.

"A/R days are now consistently in the mid-30s," reports **Kim Roberts**, MBA, RHIA, CRCS-I, vice president of the revenue cycle.

New patient access processes prevent claims denials and get claims processed more quickly. As a result, A/R days were cut from 40.5 in fiscal year (FY) 2016 to 34.2 in FY 2017.

"We also have been working to improve the aging of our receivables via special projects to decrease our A/R over 90 days," says Roberts.

Many back-end functions have moved to the front end. "We get it right the first time. This eliminates costly rework and delays in payment," says Roberts.

"WE GET IT RIGHT THE FIRST TIME. THIS ELIMINATES COSTLY REWORK AND DELAYS IN PAYMENT."
— KIM ROBERTS, ABINGTON-JEFFERSON HEALTH

Fine-tuning Authorizations

"We have spent a lot of time on authorizations, and continue to do so," says Roberts. Often, the Healthcare Common Procedure Coding System (HCPCS) code on the claim ends up being different from the one that was obtained originally by the registrar. This certainly means a denied claim.

"Our imaging department has put out a comprehensive guide to help the physicians in prescribing and ordering the correct tests," says Roberts. This is the first line of defense against incorrect authorizations. To catch the ones that do slip through the cracks, the department

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developed a "matching report." "This shows the authorization and associated HCPCS that was approved, and the corresponding order that was completed and the HCPCS associated with that order," says Roberts. If the two HCPCS codes differ, the claim will be denied. By flagging the problem early, patient access can call the payer to have the authorization updated.

"Not too long ago, if we billed and got a denial, the business office follow-up person would make the call and get the authorization updated," says Roberts. Most payers now require the authorization to be updated within 48 hours of the service.

"We have moved this function to patient access," says Roberts. "This avoids denials and speeds up the process of payment."

Front End Manages Denials

Organizations usually leave it up to the billing office to deal with denied claims. This is a missed opportunity to identify mistakes made by patient access that contributed to the denials, however.

"Little information is shared with the front end to address consistent errors," says **Benjamin Colton**, a principal at ECG Management Consultants, a Seattle, WA-based healthcare consulting firm with expertise in revenue cycle optimization.

Patient access needs to fix their own mistakes to ensure only "clean" claims are submitted. "To that end, we encourage organizations to consider routing these issues to the front end," says Colton.

At Orlando (FL) Health, the patient access department is currently in a redesign phase. Denial management is a major focus. While the back end traditionally handled denied claims, this has changed.

"We are bringing the expertise from the back end to the front end," says **Bridget B. Walters**. Walters is former corporate director of patient accounting, and recently became corporate director of patient access. "I had created the denials management team a few years ago," she says. "Collaboration with all the departments made it successful."

The denials task force team is now the domain of patient access. "Work groups tackle the root cause of the denial," says Walters. "They report back to the leaders of the task force team on how they are preventing future denials."

There is no question that moving denials management to patient access is increasing the clean claims rate. "We are seeing increased point-of-service collections, decreased A/R days, and reduced cost to collect," says Walters.

EXECUTIVE SUMMARY

Accounts receivable days were cut by 15% in one year by moving back-end functions to the front end at Abington-Jefferson Health. Departments have included the following tasks as part of the patient access role:

- Ensure authorizations are updated in required timeframes.
- Contact payers if authorizations change from what was originally obtained.
- Determine the root cause of claims denials.

The denial management manager was transitioned from patient financial services into the central access office. This department is responsible for insurance verification, authorizations, and quality assurance.

"We are focused on preventing the denials, with processes in place prior to billing," says Walters. The entire patient access team was educated on denials prevention, A/R, charity, and bad debt.

"We set up alerts to capture critical data elements that need resolution to prevent the denial," says Walters.

Patient access created a scorecard to track point-of-service collections, patient experience, and quality. "This is shared with the team and leadership," says Walters. The scorecard shows the total amount that could have been collected at the point of service and the percentage that actually was collected. Other key metrics include accuracy percentages, the clean claims rate, and A/R days by facility.

"We have seen overall denial rates decrease and point-of-service collections increase," says Walters. "Quality scores have increased overall."

Earlier in Process

Various revenue cycle tasks have been moved earlier in the process, even to the pre-encounter stages, at Abington-Jefferson Health. The department made these changes:

1. Patients are asked to pay out-of-pocket costs at the point of scheduling.

First, patient access obtains a copy of the patient's script from the physician's office. This way, Roberts explains, "there is no question as to the service to be provided." Once this is verified, registrars make a single "schedgistration" call. This includes:

- scheduling a patient's service;
- verifying the patient's insurance coverage;
- determining requirements for any referrals and/or precertifications;
- validating medical necessity;
- attempting to collect the patient's out-of-pocket responsibility.

If a patient is unable to pay at the point of scheduling, the registrar collects the balance due at the point of service. "We have consistently collected over 1% of net revenue at point of service," says Roberts. "This decreases A/R days, along with collection expenses."

2. Patient access moved various payer edits to the registration system.

Registrars validate and update data while the patient is still present. "A cleaner claim can be produced and payer denials can be avoided," says Roberts.

3. Registrars visit emergency department patients at the bedside, after triage and stabilization.

"They complete their registration, obtain required signatures via e-pads, and inform the patient of their copay to be collected upon discharge," says Roberts.

4. Financial counselors meet with patients in hospital rooms, on the nursing unit, in the clinics, and by appointment.

The counselors help patients obtain insurance coverage or set up payment plans.

"We have partnered with an agency to make long-term, interest-free payment plans available," says Roberts. "These can extend upward of 36 months, and are very accommodating to our patients' financial needs." ■

SOURCES

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Is Imaging Test Needed 'Stat?' Don't Risk 'No Auth' Denial

Be proactive with payer communication

A sudden uptick in denied claims for "stat" imaging led to some important changes for the patient access department at Palos Health in Palos Heights, IL. In almost all cases, payment was denied because of failure to obtain authorization.

Previously, payers reimbursed for any stat order without problems. That has changed. "Recently, we've seen an increase in denials — no matter what the business office was doing on the back end to try to secure payment," reports **Dan Landsman**, patient access manager.

EXECUTIVE SUMMARY

Payers increasingly are denying claims for "stat" imaging because of no authorization. The following practices can help avoid problems:

- Alert the verification team of a patient's need for stat imaging.
- Contact physicians' offices to get the required clinical documentation.
- Ask radiology technicians to identify if incorrect tests were ordered.

Earlier Notification

As of October 2016, patient access took on the role of obtaining authorizations for imaging services. The department devised a simple but effective solution to combat the surge in denials by creating an email distribution list.

The group of 15 recipients includes the vice presidents of finance and support services, radiology leadership, scheduling verifiers, and patient access leadership. Whoever schedules a stat imaging test emails the entire group with the patient's name and medical record number, the type of imaging and location, and the name of the ordering physician.

"It's really increased communication between the front end and the authorization piece," says Landsman. "This is something that really wasn't being handled before."

Once the verification team receives the email, they inform the payer right away of the patient's need for stat imaging. "We believe it will lead to a reduction in denials," says Landsman. "It will also allow the billing office to do what they do best."

Prompt notification makes it difficult for payers to argue that patient access failed to contact them in the required timeframe. "There's a discussion within that initial time frame, instead of a claim going out three or four days later with no communication," says Landsman. The same process is used at the health system's newly opened, freestanding imaging center.

Previously, the back end appealed the denied claims, but with little success. Even if a claim ultimately was paid, it was a very time-consuming process. "The lifespan of getting a denial overturned can be months," explains Landsman. "The ultimate goal is that a clean claim goes out the first time and gets paid."

Clinical Need Challenges

About 10 to 15 stat imaging tests are scheduled each day. The number is expected to increase with the opening of the new imaging center, since most of the health system's physician practices are located in the same medical building.

Patient access director **Katie Freese**, MBA, explains, "We never had a process for this before. We made an assumption that because it was an emergent need, an authorization wasn't needed."

Even with stat requests, payers sometimes want proof that the test was really medically necessary. If the physician is within the health system, this is an easy task. Patient access simply pulls documentation from the electronic medical record. However, if it's a patient from outside, the team has to contact the physician's office. Some are very accommodating; others are less so. "That can be challenging," says Landsman. "But the verification team does everything it possibly can to obtain that information."

A similar process is used for add-on patients. These patients are treated the same as stat patients, unless verifiers get a sudden surge in volume. "We can't always treat an add-on like a stat," says Freese. "That is probably the ultimate in customer service. But the reality is, our resources are limited."

If an add-on can't be scheduled immediately, registrars use this scripting: "We would love to schedule your CT scan. We'll go in this private room and get a scheduler on the phone."

Turnaround time for imaging usually is very quick, however, keeping satisfaction scores high. Landsman credits this to good communication: "There have been plenty of times when, in talking with scheduling, we find ways to get patients the service they need."

Changes "on the Fly"

Another frequent cause of imaging denials is that something changes during the actual procedure. "There's a lot of things that happen on the fly when the patient is on the exam table," says Landsman. It may be that a CT with contrast is needed, but the only authorization in place was for a CT without contrast.

Doing the second test on the spot can save the patient from scheduling a follow-up appointment and avoiding needless radiation exposure. To head off problems, patient access asked radiology technicians to look at schedules days in advance. "If they see something that should be changed, they alert us," says Landsman. Two common examples:

- An order is for CT with and without contrast, but only a CT with contrast is clinically indicated;
- The order is for CT of the abdomen or pelvis, but payers are

likely to want the target organ(s) identified.

Technicians alert patient access of any discrepancies. "We then reach out to the provider and get updated orders," says Landsman. "If a different authorization is required, we are able to get that." ■

SOURCES

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Incorrect or Incomplete MSPQ? Either Way, It's Lost Revenue

Registrars often record responses verbatim

"Did you have an accident?" "What was your date of retirement?" "Are you within your coordination period?"

With questions like these, it's no wonder that proper completion of the Medicare Secondary Payer questionnaire (MSPQ) causes major headaches for patient access.

"Read the questionnaire and imagine a reasonably educated 65-year-old trying to make heads or tails of any of it," says **Kevin Willis**, director of Medicare services at Claim Services, a claims adjusting company based in Aurora, IL. Willis, a former Medicare Secondary Payer auditor, frequently lectures on this topic.

Often, registrars have no idea why any of the MSPQ information is necessary. "The common belief is that these questions are just a way the Medicare program makes us all jump through hoops," says Willis.

Not a Dictation Tool

Patients hate being asked the same annoying questions every time they come in. "What percentage of any patient population knows exactly what qualifies as a group health coverage?" asks Willis. "How many understand how and when a federal grant covers the services they are about to receive?"

The inevitable incorrect responses cause many problems for patient access. "The document itself is treated by many patient access staff as a dictation tool — 'I'll read this, the patient will say something, I'll capture it, and we'll move on,'" says Willis.

Registrars simply record what the patient says, without offering guidance or interpreting what the patient really means. "The MSPQ is designed to guide the registrar through the process of interviewing the patient," explains Willis. "It's akin to a game of chess."

The end result is always a little bit different, based on the individual patient's particular situation. "It's not just reading something to somebody," says Willis.

If asked, "What is your date of retirement?" patients get frustrated because they can't come up with the exact date. The patient also doesn't know the reason for the question. To get the correct response, the registrar can instead simply ask, "Did you work after you received Medicare?"

"Patients can understand that question's value," says Willis. The registrar can further explain, "Well, Medicare just wants to know the last time you worked. And if you retired before you got your Medicare, we'll just use the Medicare date."

Registrars who read the MSPQ verbatim may find themselves asking a 25-year-old who is entitled to Medicare due to a disability when he or she retired. "If instead, you ask that same patient if they worked after getting Medicare, you appear a lot less dimwitted," says Willis.

Only Partially Complete

MSPQ completion is the focus of many training sessions at Thomas Jefferson University Hospitals in Philadelphia. "It has presented its challenges, for sure," says **Barbara**

EXECUTIVE SUMMARY

Incomplete or inaccurate completion of the Medicare Secondary Payer questionnaire causes significant problems for the revenue cycle. The following strategies can help prevent those problems:

- Offer guidance instead of merely reading questions verbatim.
- Tell patients why information is needed.
- Interpret patients' responses instead of simply recording what they say.

Rubino, CRCE-I, director of patient access.

Sometimes, the troublesome task needs to be done without a patient physically present. "When we don't see patients face-to-face, getting the form completed can be a challenge. We then need to follow up," says Rubino. The MSPQ is a requirement for all Medicare patients and registrations, recurring every 90 days. "Luckily, our form is electronic within our registration pathway. It automatically fires appropriately during registration," says Rubino.

New employees are trained on how to complete the form. Monthly reports are run for quality assurance. "We now can run a report on 'complete,' 'partial,' and 'not at all,'" says Rubino.

The most common problem is that registrars fail to complete the MSPQ in its entirety. "Our training sessions include the requirements from Medicare, how to complete the form, why it is needed, age, disability, end-stage renal disease, practice sessions, and a final assessment," says Rubino.

Incorrect Information

Confusing questions and annoyed patients aren't the only problems registrars face with MSPQ completion. They're also dealing with faulty data. "Patient access is bombarded with incorrect information — from patients and even from payers," says Willis.

If a patient presents with face lacerations and a fractured femur that occurred from a fall injury at a friend's home, he or she will probably answer "no" if asked, "Did you have an accident?"

"But that's the wrong answer," says Willis. Patients assume the registrar means a car accident, without realizing injuries that occurred in someone's home are covered by homeowner's insurance. "If the patient cut their finger at someone's house, nine times out of 10, that's not identified at registration," says Willis. "But if it is, we've identified a payer that pays dollar for dollar, instead of the contractual reimbursement, and pays quickly."

Every registrar knows patients want to be asked as few questions as possible. "If they say 'yes' to the accident question, now you have to ask more questions," says Willis. Failing to probe further often leads to the incorrect payer being selected. No scripting can cover all situations. "I believe scripting is a house built on sand in this arena — not that I haven't tried," says Willis.

> "PATIENT ACCESS IS BOMBARDED WITH INCORRECT INFORMATION, FROM PATIENTS AND EVEN PAYERS."

Nothing replaces a registrar understanding a question, he emphasizes: "In the case of accidents, no registrar can properly administer the question without first understanding no-fault insurance, liability insurance, and how each can be introduced as a result of an accident."

Don't Play Blame Game

Getting an accurate MSPQ is a team sport: It's a joint effort between the front end and the back end.

"There is a rivalry, in almost every hospital system, between registration and financial services — what I call the blame game," says Willis.

Billing usually faults patient access for completing the form incorrectly. "But there is tons of information that can't possibly be gleaned at the time of registration," says Willis.

There's no way around it — the missing information has to be corrected or added later. "There has to be a burden on the person who is actually formatting the claim to polish it," says Willis.

For instance, an injured patient coming to the ED after a motor vehicle accident probably won't even know the name of the other driver, let alone the name of the attorney who will handle the eventual claim. The information is just not available at that point in time.

"While there is a system in place for follow-up with auto accidents, there are other types of liability cases — slips and falls, for instance — that aren't quite as simple," notes Willis.

Patient financial services often takes the stance that it's "registration's job." The problem with that is that an incorrect or incomplete form causes problems for the entire revenue cycle, says Willis. At a minimum, identifying the wrong insurance increases A/R days.

"The best case scenario is you bill the wrong insurance primary, they tell you no, and now you have to go to the right insurance," says Willis. "You've just cost yourself a couple of weeks in receivables."

An even worse scenario: a lost chance for any payment at all. This often occurs if Medicare pays as the primary insurance when they aren't supposed to, or a commercial payer does so. The claim is paid — but the payer corrects the mistake months down the road.

"It is commonplace for a payer to pay as primary, only to retract its payment — oftentimes over a year later, and say, 'Wrong payer! You should have billed Medicare — sorry!'" says Willis.

By that time, it's too late to recoup payment from the correct payer. The lesson learned, says Willis: "When we identify the right payer at the time of registration, everybody benefits." ■

SOURCE

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What Do Registrars Do All Day? Many in Hospital Have No Idea

Rudeness stems from poor understanding of patient access

Are registrars treated rudely by clinicians or other hospital departments? Often, poor understanding of their jobs is the underlying reason.

"We have this struggle often in our facility. My staff was feeling disrespected and underappreciated by most of the departments that we interact with," says **Marci Mollman**, director of patient access at Holy Rosary Healthcare in Miles City, MT.

To educate others on their role, lead associates created an eight-minute video titled, "A Day in the Life of Patient Access." "We tried to put a face to all of our associates, so that everyone could see how many areas we really touch every day," says Mollman.

The video was shown to staff and hospital administration. "The video was created by the associates making a script and creating cue cards," says Mollman. "They recorded us on their phones, then another associate cut and edited all of the snips into a video."

Afterward, patient access distributed a questionnaire asking how they could improve interactions with other departments. (*See the department's questionnaire in this issue.*)

"It generated some really good conversation, and opened some eyes," says Mollman. "For the most part, we have seen improvements."

Below are other ways patient access can respond to rudeness:

• Address incidents right away.

Incidents of rudeness toward registrars at Sisters of Charity Leavenworth Health System have decreased noticeably. This is because of a concerted effort to educate people about the role of patient access. Occasional problems do crop up, though — and when they do, registrars aren't silent about it. "We, of course, still have those who find it necessary to treat others poorly," says Mollman. "I am always there to defend and help them."

Tanya Hampton, manager of patient access services in the ED at Methodist University Hospital in Memphis, TN, takes a proactive approach if she overhears a registrar being treated rudely: "I don't tolerate that, and I go tell them that right then and there," she says. Although Hampton is always polite, the message is clear: Registrars are not to be mistreated.

Speaking face-to-face elicits an immediate response, says Hampton: "It's not like an email or phone call that they can ignore. We are working really hard to change the mindset of these folks."

• Educate clinicians on the role of bed management.

Sometimes, clinicians are dismissive of bed management staff at Hackensack UMC Palisades in North Bergen, NJ. "The authority they are afforded to make decisions on where to place patients, depending on diagnosis and status is, at times, undermined by the clinical staff on the specific units," explains patient access director **Maria Lopes-Tyburczy**.

Clinicians don't realize the importance of telling bed management what's going on in the unit. If there's an emergency situation

EXECUTIVE SUMMARY

Clinicians and other hospital departments often lack even a basic understanding of the patient access role. At times, this leads to disrespectful attitudes. Consider these approaches to help interdepartmental relationships:

- Create a video to explain the patient access role.
- Inform physicians of the steps involved in scheduling their patients.
- Ask nurses to observe the registration process.

with a patient, for instance, another patient awaiting an available bed is delayed. If bed management staff are kept in the loop, they can be upfront about how long it will take to transfer the patient to a room, says Lopes-Tyburczy.

Sometimes there is a need to transfer patients within the unit. If bed management staff don't know about it, an occupied bed might end up being booked for another patient. "This causes delays in placing the patient," says Lopes-Tyburczy.

Getting clinical staff and patient access on the same page is the only solution. "Collaboration between clinicians and bed management staff is crucial for patient safety, positive outcomes, and experience," says Lopes-Tyburczy.

• Clear up misunderstandings about who is responsible for obtaining prior authorizations.

Part of a financial counselor's job is to inform physicians' offices about pre-authorization requirements, says Lopes-Tyburczy. Often, they get a less-than-polite response from overworked office staff who don't appreciate what they perceive as additional work.

In this situation, says Lopes-Tyburczy, "Educate the referring office that ultimately it's *their* responsibility to obtain pre-authorizations." Doing this collaboratively avoids treatment delays.

• Explain the registration process.

Many envision registrars' role as simply sitting at a desk and checking people in with a few clicks of the mouse. Thus, they're quick to place blame if any glitches arise. **Marion Knott**, manager of clinic access at Moffitt Cancer Center in Tampa, FL, says, "Many departments and providers don't understand what we do exactly." Knott finds it helpful to explain the registration process when other departments get testy. After she does so, the registrar probably won't get an apology. "But it usually doesn't happen again," says Knott.

Nurses and physicians complain that orders aren't scheduled quickly enough, without realizing the process. "They don't see what it looks like from our side, and what we have to do with the information," says Knott.

Recently, a provider put in multiple orders. The registrar wasn't able to schedule the orders until the specialty orders — which are done in date order — were completed. "He sent an email copying the chair of the department and administrator, and wanted heads rolling," says Knott. The physician was angry because he felt his patient wasn't being scheduled quickly enough. After she explained that the process was held up whenever there is scheduling that is divided, the provider was more understanding.

• Have good documentation at your fingertips.

Evidence of who gave what instructions comes in handy if registrars are unfairly blamed just for doing their jobs. "We play middle man a lot," says Knott. "People don't realize that we are just doing what we were told to do."

In one case, a nurse practitioner asked a registrar to overbook the

Invite Critics to Watch Registration Process

Staff at one particular clinic always seemed very critical of registrars at Sisters of Charity Leavenworth Health System in Miles City, MT. Realizing the clinicians had no idea what the registration process entailed, patient access leadership asked nurses to watch them at work.

"We asked their manager for dedicated time with them, and she allowed it. We then set the agenda to show them our workflows," says patient access director **Marci Mollman**.

The nurses had no idea what it took to register a patient, complete an Advance Beneficiary Notice of Noncoverage, or process lab orders. "They were really shocked at all of the steps that it took," says Mollman. "It has gone a long way to improve relationships."

When **Marion Knott** started out as a patient access representative more than a decade ago, a manager seemed very confused about scheduling procedures. Knott explained the entire process in detail. "She was in shock and said in amazement, 'You have to do this with every patient?'" says Knott. "It showed me that people really don't understand what we do."

Knott is now manager of clinic access at Moffitt Cancer Center in Tampa, FL, and still encounters the same problem today. Patient access currently is working with nursing leadership to arrange shadowing between the two departments.

"When new nurses or patient access reps start, we want them to spend a couple of hours sitting next to somebody and watching what they do," says Knott.

Clinical researchers also have agreed to shadow registration, so they can fully comprehend the scheduling process. "Their orders are very date-specific, and can be pages long," says Knott. "They don't understand the complexity of what we have to do." ■

Ask Other Departments to Rate Patient Access

Below is a survey used by the patient access department at Sisters of Charity Leavenworth Health System in Miles City, MT.

In an effort to improve our effectiveness in working with other departments within our facility, Patient Access would like to ask you a few questions.

1. Which department do you primarily work in?

2. How effectively does Patient Access communicate with your department?

(Not effectively) *(Very effectively)*
1 2 3 4 5 6 7 8 9 10

3. Are there any specific communication methods or techniques that Patient Access should continue or discontinue?

4. Do you have any ideas to help Patient Access improve communication with your department?

schedule at a physician's request. That physician later angrily confronted the registrar — who gently reminded him that he'd given permission to overbook his template — and had documentation to prove it.

Although this kind of evidence is great to have on hand, things must be handled diplomatically. "We say, 'Is this what you wanted? Because this is what I see here,'" says Knott. "We don't want to cause waves. We want to smooth things out." (*See related story in this issue on having other departments observe registration.*) ■

SOURCES

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Online Modules Cut 2 Weeks of Patient Access Training

Identify and change ineffective approaches

Onboarding training for new patient access employees was cut from seven weeks to five weeks at Los Angeles-based Ronald Reagan UCLA Medical Center, mainly because of expanded use of online training modules.

"The modules range from beginner to moderately advanced and can be modified at any time," says **Drew D. Totten**, principal administrative analyst for patient access services.

Initially, employees took all the modules over a two-day period. "We found this was ineffective, particularly with new hires," says Totten. "They didn't retain the information."

Employees now take a single module at a time. First, they demonstrate the relevant skills on the job. "Once they've mastered that, they take another module," says Totten. "They get a better grasp of the material that way."

The previous practice was for UCLA's new hires to shadow employees. This gave them exposure to their actual job duties. "But due to inconsistent training, we made the change to our current practice. We

have seen positive gains," says Totten.

The online training saves resources and time. Productivity is higher, since most employees take the modules during downtime at work. "It also frees up the manager, who previously had to cover everything that's now in the online modules," says Totten. Another advantage: Every patient access employee gets information in the same exact way.

Online training doesn't always translate well to face-to-face encounters, though. "It's like becoming a police officer. You go to the training academy, but when you hit the streets it's completely different, due to the different scenarios the employee will encounter," says Totten. He names these as some of his biggest training pain points:

• Properly entering the patient's primary care physician.

"This was often done incorrectly, but the online training has made it a non-issue," says Totten.

Often, entering the primary care physician information was overlooked. Registrars viewed it as an unimportant piece of data. "The online training and hands-on reinforcement has cause our department error rate to drop from 30% to 8%," says Totten.

• Medicare Secondary Payer questionnaire (MSPQ) completion.

Prior to online training, the form was completed incorrectly "nine out of 10 times," says Totten. "We're really stressing hard the proper steps of completing that properly." Covering every possible scenario is impossible. "So as new scenarios come up, instead of having staff retake the entire MSPQ training, we just have a huddle to cover the minor tweaks or finer points," he says.

• Third-party liability.

If an ED patient comes in after an automobile accident, the insurance of the person who hit them may pay the bill, instead of the patient's primary insurance. "Those type of scenarios have been integrated into the training and are closely monitored to be sure they are effective," says Totten.

ONLINE TRAINING SAVES RESOURCES AND TIME. PRODUCTIVITY IS HIGHER, SINCE MOST EMPLOYEES TAKE THE MODULES DURING DOWNTIME AT WORK.

• Point-of-service collections.

"Most of the people we hire for pre-registration have never done it." says Totten. "If employees simply follow the scripting, they're successful. It's that simple."

Online training modules for collections have helped many reluctant collectors. "These have affected our collections, at least in our pre-registration department, substantially," says Totten. "We are breaking records in that area." Pre-registration collections have increased about 40% because of improved training and monitoring.

If an employee is having difficulty with collections, two things are done:

1. Managers listen to recorded calls.

"These calls are also reviewed with the employee to identify successes and areas of opportunity," says Totten. They look to see that the employee is following the scripting for collections.

"In regard to scripting, we are looking for consistency and urgency," says Totten. An example would be that immediately after the liability is discussed with the patient, the employee must always ask, "How would you like to pay for that today?"

"If the patient is somewhat hesitant to provide credit card information over the phone, our secure online payment portal is an option," says Totten.

2. The employee does role-playing with a manager who pretends to be a patient.

"We want the employee to sound natural and not scripted," says Totten. "It's all about making sure the employee is comfortable in their verbiage."

Many employees get results after the role-playing, but for some, the improvement doesn't last. "We are still looking to shore up our processes for training, to get everybody at the same level with collections," says Totten.

EXECUTIVE SUMMARY

New patient access employees' training was cut by two weeks with expanded use of online training modules. The following strategies can be used to tweak training:

- Ask new hires for feedback on training.
- Ensure modules are challenging but not impossible to pass.
- Cover all aspects of registration before department-specific training.

Evaluate Training Approaches

Totten continually evaluates his own training approaches. He always asks new hires what they thought was good and bad: "If the training is flawed, it must be fixed." Here are some recent tweaks made to patient access training at UCLA:

• Several questions were reworded because they were unintentionally tricky.

"Some of the fill-in questions could have had multiple answers," Totten explains. "The test has been modified to identify all possible answers."

• A module was made less difficult because few patient access employees were passing it.

"Modules should be challenging, but not so much that no one can succeed," says Totten. Initially, the patient access coordinator module took four hours. "That is too much material to retain in just one exposure session," says Totten, who broke it up into three smaller trainings. "This ensures the user is engaged and not overwhelmed. This also allowed me to shorten the assessments."

• The number of acceptable answers was expanded for some "fill in the blank" questions.

The correct answer for the question "In securing patient valuables, you must have a _____ present whenever the safe is open," is "security guard." However, "guard" or "witness" are also acceptable answers.

Similarly, for the question, "The COA informs patients that UCLA is a _____ hospital and that their case may be reviewed by medical students," there are multiple acceptable answers. These include "teaching," "instructional," and "research."

Patient access leaders at Riverside Regional Medical Center in Newport News, VA, recently made an important change to initial training for new hires. The department switched to a structured classroom training environment.

"This has proven effective with our new hires, and can be shown in their progress once in the department," says patient access director **Melanie Stanius**, CHAM.

Previously new hires were trained exclusively in the department. They were paired with an experienced registration representative and observed actual patient registrations. "The change to a standardized classroom training has allowed the new hire to come in with a solid foundation for us to build upon during the department training," says Stanius.

New hires now complete three days of classroom training with a patient access trainer. This covers all aspects of registration — compliance, rules and regulations, and workflow. "This results in less frustration and confusion for the new team member as they begin their department-specific training," says Stanius. ■

SOURCES

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Be Proactive, Not Reactive, With Patient Access Training

In the past, the patient access department at St. Peter's Hospital in Helena, MT trained using a "very reactionary approach," says **Devon Murray**, executive director of the revenue cycle. "We relied mainly on denials and complaints to drive our continued education."

Patient access managers only followed up with staff when specific concerns were raised, such as missing insurance information or incorrect patient information causing claims denials. "We are rolling out a much more proactive approach," says Murray.

Managers now use leadership reports and individualized scorecards to track each individual's performance in relation to quality and productivity. "We set targets for each area of patient access to achieve," says Murray. "All employees that do not meet these targets receive additional training to help them succeed."

Registrars can see how their performance compares with previous months and departmental expectations. "This allows staff to identify opportunities and take ownership for their own success by making consistent improvements month over month," says Murray.

Murray says these three things are essential to effective patient access training:

1. Setting clear expectations.

Department expectations and policies and procedures are clearly outlined in training materials, and made available for staff to reference. "We are in the process of adding patient access-specific policies and procedures into our standard training manual," says Murray. These include registration accuracy, privacy policies, and insurance verification.

New staff are required to read the manual and sign, noting that they have read, understand, and agree to comply with the policies. As policies are updated, changes are sent to all staff to be signed.

2. The ability to see how overall department and individual staff performance compares against industry benchmarks.

The department's reports track registration accuracy, eligibility verification rates, the number of errors that have not been corrected within three days of the patient admission, and point-of-service collections.

3. Sending a consistent message.

"In order for training to sink in, it needs to become a part of your culture," says Murray. These approaches promote consistency:

• Reminding staff of policies and expectations during all staff meetings and regular huddles;

REGISTRARS CAN SEE HOW THEIR PERFORMANCE COMPARES WITH PREVIOUS MONTHS AND DEPARTMENTAL EXPECTATIONS.

• Providing additional one-on-one training to registrars who are performing below expectations.

"We have been working a lot to help staff make our systems work for them," says Murray. For instance, the department has a real-time eligibility tool in place, but registrars don't always interpret the benefits section of eligibility responses correctly. As a result, it isn't clear if patients are really covered for their scheduled service. "They frequently miss valuable information," says Murray. "We are training staff to read the entire response." ■

SOURCE

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COMING IN FUTURE MONTHS

- How new Medicare ID cards will change patient access
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