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OCTOBER 2017 Vol. 36, No. 10; p. 109-120

INSIDE

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Prior Authorizations: 'Top Issue Within the Revenue Cycle'

'Completely out-of-control' requirements

Ask any patient access leader to describe his or her biggest headache, and the answer likely will have something to do with the authorization process.

"The authorization process is probably our top issue within the revenue cycle," says **Margaret Schuler**, system vice president of revenue cycle for Ohio Health.

Patient access departments struggle to keep up with all the authorization requests. "It's gotten completely out of control. The payers are making up their own rules," says **Karen Hoppe**, a senior consultant at Craneware, an Atlanta-based company specializing in revenue cycle improvement.

Patient access departments lack sufficient resources to appeal all of the "no auth" denials they're facing — something that hasn't gone unnoticed by payers. "Payers are using that as a 'do not pay' tactic — what's the percentage of denied claims that are really going to get reworked?" asks Hoppe.

"THE AUTHORIZATION PROCESS IS PROBABLY OUR TOP ISSUE WITHIN THE REVENUE CYCLE." — MARGARET SCHULER, OHIO HEALTH

The sheer number of denials is overwhelming many departments. "I've never seen so many claims denied as in the past year or two, and I've been in the business since the early '90s," says Hoppe. "It's amazing to me how payers can consistently deny claims and hospitals have no recourse."

Legislation: Partial Solution

Some states have passed legislation addressing "surprise" medical bills in response to public outcry over patients being stuck with unexpected high costs due to a hospital or provider's out-of-network status. "But I don't hear a

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management™,
ISSN 1079-0365, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
AHC Media
P.O. Box 74008694
Chicago, IL 60674-8694

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Back issues: $80. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

AUTHOR: Stacey Kusterbeck
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lot about how payers are denying claims," says Hoppe. "I would love to see more being done at the federal level so the payers cannot be just denying claims without good reason."

A growing number of states are passing laws to curtail payers' authorization practices. Delaware, Ohio, Arkansas, and Virginia all have passed prior authorization legislation.

"Ohio's Prior Authorization Bill is a great first step to improving the issues," says **Angela Ferguson**, MBOE, director of patient access services and precertification at The Ohio State University Wexner Medical Center in Columbus. The following provisions went into effect Jan. 1, 2017:

- Insurers must disclose all prior authorization rules to providers at least 30 days in advance of the new requirement.
- Enrollees of the health plan must receive basic information about which drugs and services require prior authorization.
- Providers are allowed to request a "retrospective review" for unanticipated procedures that were performed during an authorized procedure, with some limitations.
- Providers are allowed to request a "retrospective review" for services that required a prior authorization that was not obtained, when certain criteria are met.

As of Jan. 1, 2018, insurers will be required to have a web-based system to receive prior authorization requests and a faster timeframe for prior authorization decisions.

"Insurers also will need to include more clarity when responding to a prior authorization request, including acknowledging receipt of the request and specific reasons if denying," says Ferguson.

The newly enacted legislation is welcome, but timeframes are still too long, says Ferguson: "Payers will still have 10 days to respond to non-urgent requests, and 72 hours to respond to urgent requests."

Standardized timeframes for all payers is one of the biggest advantages that Ferguson sees with the legislation. Currently, payer timeframes vary widely. "There are payers who take 14 days, 21 days, or 30 days," she explains. "It is very challenging for staff to manage all these different timeframes."

If a test is scheduled seven days out and the payer has a 14-day turnaround time, the authorization may not be in place in time. This requires a conversation with the provider.

"If the test can safely be rescheduled, we will do that. If it can't, we move forward," says Ferguson. "Sometimes those turn into cases that you have to do appeals

EXECUTIVE SUMMARY

A growing number of states have passed prior authorization legislation to combat payer requirements resulting in delayed care, lost revenue, and dissatisfied patients.

- Patient access departments lack resources to appeal the surge in denied claims.
- A coalition created criteria to streamline prior authorization processes.
- Some health plans have agreed to eliminate authorization requirements for hundreds of services.

Fight Surge of Medical Necessity Claims Denials

Other payers are following Medicare's lead in denying claims for medical necessity.

"Prior to the past few years, we've only seen Medicare denying for Local Coverage Determination policies," says **Karen Hoppe**, a senior consultant at Craneware, an Atlanta-based company specializing in improvement of the revenue cycle. Now, commercial payers, Medicare Advantage payers, and the Medicare managed care payers are doing so.

"Medicare is very strict, and we have to follow their guidelines," notes Hoppe. "But nobody is keeping these commercial payers in line."

One obstacle is that some of the tools patient access uses to check current procedural terminology (CPT) and diagnosis requirements only look at Medicare's policies. These tools usually do not include other payers since, until recently, medical necessity denials from commercial payers were uncommon. "Hospitals are incurring denials from other payers that they are not used to seeing," explains Hoppe. "Hospitals need software that pulls in all the other payers' policies."

If the diagnosis code on an order is not going to pass medical necessity requirements, patient access has to contact the provider's office to obtain a new diagnosis. Next, patient access has to contact the payer.

"It's a very cumbersome process — one which is hopefully done prior to the patient coming in," says Hoppe.

To prevent medical necessity denials, patient access departments can do these three things:

1. Set up a one-on-one education session for high-volume practices to discuss why medical necessity denials are happening.

"It's often front-desk staff or a nurse who fills out the orders and are not familiar with medical necessity requirements," says Hoppe.

Doctors often think they know the payers' medical necessity policies — but are not coding to the specificity that the payer requires. "Sit down with the physician offices and show the denials by the payer," says Hoppe.

2. Enlist the help of higher-ups.

"A successful approach requires buy-in of the hospital's chief medical officer," says Hoppe. This individual can contact physicians who are not complying with medical necessity requirements.

3. Create a daily report to see if the test ordered or scheduled matches the test that was actually performed.

The report should be run the day after the patient's visit. "When you find any discrepancy, get a new authorization and run the new CPT code through medical necessity software," says Hoppe.

However, many payers do not allow retro authorizations. "The hospital is going to end up writing those off and having a loss for those procedures," says Hoppe. ■

on, and sometimes are ultimately written off."

The legislation will not affect the number of services requiring authorizations. "There's the chance that payers will require authorizations on a broader scope of services," says Ferguson.

Previously, payers required authorizations mainly for high-dollar procedures, primarily surgeries. Now, payers also are requiring authorizations for high-volume procedures. "Even though MRIs and CT scans are not the most expensive procedures we do, the volume is greater than surgical procedures," says Ferguson.

Although the legislation won't solve all authorization headaches for patient access, it has called attention to the issue. "If nothing else, it's making people more aware of all the behind-the-scenes work that has to be done because of the requirements of the payers," says Ferguson.

Schuler says consistent medical necessity standards are needed: "If payers and providers could agree on medical necessity standards across the industry, we wouldn't need the authorization process."

Because the problem has not been addressed federally, states are developing their own regulations. "The payers are national payers. From the payer's vantage point, they are going to now have to put in processes which address each individual state," says Schuler.

Automation Is Needed

Part of the problem with prior authorizations is that the process is very manual. "It becomes a rework process over and over again," says Schuler.

Payers already have invested significant resources in their provider portals. The problem is that the portals are not automated. Patient access has to go to many different portals to find information on what's

Prior Authorizations Getting in the Way of Patient Care

Jack Resneck Jr, MD, chair-elect of the American Medical Association (AMA) has seen prior authorization requirements worsen in recent months: "The problem has been going on for some time, but it does seem to have exponentially increased."

A coalition including the AMA and more than 100 other healthcare organizations is urging health plans to reform prior authorization requirements for medical tests, procedures, devices, and drugs.

"We are trying to collaborate with other groups to change the playing field a bit," says Resneck. "We want to work with the health plans to right-size the requirements they have."

The coalition created a set of 21 recommended principles for prior authorizations. (The Prior Authorization and Utilization Management Reform Principles can be downloaded at http://bit.ly/2neduYK). These reflect growing concern about the authorization process interfering with patients getting needed care. "Both doctors and hospitals are feeling it," explains Resneck.

Below are some findings from a recent AMA survey of 1,000 practicing physicians.

- Practices complete an average of 37 prior authorizations each week per physician, taking 16 hours to process.
- Seventy-five percent of surveyed physicians described prior authorization burdens as high or extremely high.
- More than one-third reported having staff who work exclusively on prior authorization.
- Nearly 90% of physicians reported that prior authorization sometimes, often, or always delays access to care.

"We are all wasting time that could be spent taking care of actual patients," says Resneck.

Care Adversely Affected

Resneck, vice chair and professor of dermatology at the University of California, San Francisco, has seen a sudden uptick in prior authorization headaches in his own practice. "I make a choice that's good for the patient and I'm being responsible in selecting a generic, and it still doesn't make it through," he says.

Previously, having to obtain a prior authorization was somewhat of a rarity. It happened occasionally, such as with a critically ill patient with melanoma needing a brand new, innovative biologic drug. For the vast majority of prescriptions, though, it was "business as usual" and the payer simply paid for the drug that was prescribed.

"But that's not what I'm experiencing anymore," says Resneck. "A $50,000 biologic drug or a 40-year-old topical generic seem to be equally likely to require an hour of work to get that prior authorization."

Payers sometimes flatly deny a drug, but offer no alternatives. Physicians then end up on the phone with the pharmacist trying multiple different medications to see what the payer will approve. "It's a guessing game, because there is no transparency in the prior authorization process," says Resneck.

Other times, payers suggest an alternate medication that is clearly inappropriate for the patient's condition. Recently, a payer denied a medication for a patient with severe psoriasis who had just been hospitalized for the disease. "We had finally gotten the patient stable on a medication, and because something in their plan changed, the payer is requiring that the patient totally start over with a step therapy program — which puts the patient back on a topical cream," says Resneck.

Recently, Resneck prescribed a medication that cost his patient $20 to fill. The following week, he prescribed it

Continued on page 113

required. "It's very inefficient and ineffective. You have to comb through hundreds of medical policies. It's just not feasible," says Schuler.

Medicare is very transparent in the publication of its medical necessity criteria.

"We've had the ABN [Advance Beneficiary Notice of Noncoverage] process and NCCI [National Correct Coding Initiative] edits," notes Schuler.

The same is not true for commercial payers. "You can't buy an ABN medical necessity scrubber for the managed care payers. You have to go to every payer portal and read their individual medical policies," says Schuler. (*See strategies for medical necessity denials.*)

Payer policies are not in an electronic toolset that makes it easy to check medical necessity based on the diagnosis and current procedural terminology (CPT) codes. "Payers are also hiring companies to administer their medical policies," says Schuler.

Continued from page 112

again for a different patient with a similar plan, assuming the out-of-pocket costs would be in the same ballpark. This time, the cost was several hundred dollars, which triggered a phone call from an upset patient unable to pay for the prescribed medication.

"I get those angry phone calls all the time," says Resneck. "Patients are understandably frustrated. They are ready to move on to the next stage of their treatment or workup, and get stuck in limbo."

Patients leave physician offices with a clear treatment plan and wish to begin immediately, but are made to wait several days for the payer to decide whether or not the service is authorized. Patients may be told they need a radiology study for a diagnosis, for instance, but are held up by the payer's denial.

The coalition argues that an electronic process at the point of care is needed so providers can know which drugs are covered, if what they're prescribing requires a prior authorization, and what the cost is going to be for the patient.

"There are some attempts by payers to do that. But you have to log out of your EMR [electronic medical record] and log onto their proprietary website, ending up with passwords for 20 or 30 different health plans," says Resneck. "That's not what we're talking about."

Rather, an integrated system is needed, allowing providers to get information for all payers directly from their own EMRs. "We have to make this better for patients and doctors," says Resneck. "A few hours later, we are having to start all over again because we've hit a brick wall with prior authorization."

Requirements for "peer-to-peer" reviews are surging. The payer's physician is often from a different specialty, however. "Sometimes the peer you call really isn't somebody who's treated the same disease," says Resneck.

Continuity of care is another big concern. "Sometimes, there is a formulary change right in the middle of a benefit year, or a prior authorization is not even valid for the usual course of care," says Resneck.

Signs of Progress

There is some indication that the pressure to reduce prior authorization burdens is getting through to payers. "We have already seen a couple of health plans that have eliminated several hundred requirements," says Resneck.

Recently, BlueCross BlueShield of Western New York announced it will eliminate prior authorization requirements for 212 services. "These are small examples, but it gives me enthusiasm to keep up the work and to have conversations with other health plans," says Resneck.

The vast majority of the drugs, tests, or services that require a prior authorization are approved in the end, but only after lots of rework and delays.

This is a waste of everyone's time, says Resneck: "As a doctor, there are times when I know I'm eventually going to get a certain prior authorization approved."

He sees these services as "low-hanging fruit. Plans can start looking at changing their processes to waive those requirements." ■

SOURCE

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Most diagnostic services are managed by a third-party authorization vendor, further complicating the process.

"If authorizations are here to stay, electronic transactions are necessary to reduce costs," says Schuler.

Many Added Costs

Clinical care is being delayed because of payer timeframes. "When somebody's dealing with cancer or a high-risk medical condition, they don't want to wait for their care," says Schuler.

Patient satisfaction and customer service are top priorities for patient access, but prior authorization requirements clearly frustrate patients.

"Patients can receive unexpected non-covered services billed to them, and/or a delayed statement months after delivery of service, due to the lengthy appeal process," says Schuler.

Hoppe knows of at least one payer who routinely denies any claim without an authorization in the system, even though the authorization actually was obtained. "They are trying different tactics to deny claims," she says. "Hospital associations and state associations really have to band together to fight the payers."

Larger health systems might be able to negotiate better contract terms with payers, putting smaller community hospitals at a distinct disadvantage.

"They don't have the resources to go fight these payers. They are losing money and, ultimately, will get bought out by a bigger hospital," says Hoppe. "There needs to be more collaboration across hospitals. Many really work in their own silos." (*See story on a coalition formed to address prior authorization requirements.*)

Authorizations are an attempt to manage healthcare costs by reducing services that are not medically necessary. "But even though it appears to be reducing utilization of services, it's adding to the cost of care due to the administrative burden of the process," says Schuler.

A physician community already struggling with reimbursement cuts likely lacks resources for the labor-intensive process to authorize an ordered service at the hospital. "Therefore, either the authorization process doesn't happen, or it's performed by the hospital," says Schuler.

Many patient access departments obtain authorizations on behalf of providers. To get paid for rendered services, hospitals have to add resources to patient access and the business office. Even payers are adding resources to manage the denials ending up in appeals.

"Everyone loses in the authorization process right now — the patient the provider, the payer, and the hospital," says Schuler. "We need a solution that works for everybody." ■

SOURCES

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Don't Make Patients Come to You: Find Them

Some technology is 'early and costly'

Instead of having patients stand in a line to register or wait for their names to be called, wouldn't it be wonderful if registrars could simply walk up to them?

Plastic tracking badges allow this by broadcasting patients' locations in real time, but the technology is "both early and costly," says **Anthony Gordon Brooke**, vice president of ambulatory engineering at GetWellNetwork, a Bethesda, MD-based provider of patient engagement solutions.

The tool also has limitations. Since GPS doesn't work indoors, tracking badges use cellular signals, which are limited to 300 square feet maximum. "It requires a specialized network to be installed," notes Brooke.

Wristbands also could be used to track patients. "But instead of spending budget on badges and wristbands, use the patient's smartphone to track and guide them," suggests Brooke. "Nearly all patients come with their own smartphone, and all broadcast a unique signal."

This allows registrars to track the patients' general whereabouts, and also to offer the patient guidance through the intake process. "We have also been working with facial recognition to determine that a patient has arrived," reports Brooke.

EXECUTIVE SUMMARY

Some patient access departments are tracking patients' locations in registration areas to provide better service, with plastic tracking badges, wristbands, or the patient's own smart phone. The following are benefits of this practice.

- No overhead paging is needed.
- Patients don't need to wait for their name to be called.
- Families can be updated more quickly.

No Overhead Paging

Registrars use a real-time locating system at the Josie Robertson Surgery Center at Memorial Sloan Kettering Cancer Center in New York. Every patient and each family has a badge that allows registrars to locate them at any time. "We thus have no

overhead paging," says **Brett Simon**, MD, the center's director. "Our waiting area has a serene and peaceful atmosphere."

Instead of calling out names in the waiting area, registrars locate the person on their computer screen. "They walk over to them to give updates or information directly," says Simon. Families frequently want to know how things are progressing, and when they can expect the patient to be out of surgery and have visitors.

"Families love it. It gives them the information they need without having to ask someone at a desk," says Simon.

In addition, the following are some other unique features of the check-in process at Josie Robertson Surgery Center.

• Monitors in the waiting area prominently display the patient's progress.

Coded patient identifiers are used for confidentiality. "Families can see where their loved ones are in the process, and when they are ready for visitors," says Simon.

Families are informed of the identifier, which is a combination of the patient's initials and month/year of birth.

• Waiting areas were designed using the concept of "campsites."

"Loosely divided spaces allow groups large and small to feel like they 'own' their area, while maintaining an open, airy atmosphere with abundant natural light," says Simon.

• All registration is handled before the day of surgery.

All outstanding issues, such as insurance, pharmacy, or demographic information, are handled by patient access, so there are no delays when patients arrive.

"This helps ease patient anxiety on the day of their procedure. Patients aren't scheduled for surgery if there are outstanding registration issues," says Simon.

Patient check-in is handled quickly by unit assistants, supported by a nurse liaison who is available to manage any issues.

"These features give patients and their caregivers privacy, access to information at their convenience, a serene atmosphere, and a degree of independence at an often difficult and vulnerable time," says Simon. ■

SOURCE

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Did Payer Coverage Change? Communicate to Patient Access Quickly

Keeping the entire department apprised of payer coverage changes has become overwhelming for many patient access leaders.

"It is always challenging to stay ahead of these changes in time to get proper notification out to the end users," says **Kaniesha Mason**, CHAM, associate director of patient access services at Syracuse, NY-based Upstate University Hospital.

It is not always possible to pull all employees from their registration locations for classroom setting training. The department also struggles to train both centralized and decentralized registration staff.

"Since not all registrars work for patient access services, it can be challenging to hold all staff equally accountable for thorough registrations," Mason explains. The department uses the following strategies described below.

• A registration-related article is included in the monthly departmental newsletter.

"This is reviewed at staff meetings," says Mason.

• Employees regularly meet for 15 minutes with a supervisor.

"This provides an opportunity for staff to ask questions or demonstrate proficiency on any topic," says Mason.

EXECUTIVE SUMMARY

Updating patient access employees on payer coverage changes is a top challenge for patient access leaders. Below are some strategies to try.

- Make topics covered during "lunch and learn" sessions available for registrars unable to attend in person.
- Meet with individual employees for 15 minutes to answer questions.
- Use "hard stops" to clear up confusion.

• The department hires cross-trained staff to cover both emergency departments and central registration sites.

"We are able to share staff during peak times and schedule more end users for face-to-face training," says Mason.

• "Lunch and learn" sessions explain new processes or clarify existing processes.

Even if registrars can't attend in-person, they can still get the information. "The sessions are posted as mandatory training, with a short proficiency exam to test their knowledge," says Mason.

Performance improvement manager **Brenda Passardi**, CHAM, hosts the monthly lunch and learns. The sessions are held at different times and at different facilities to accommodate all staff regardless of shift or location. "We select topics that serve as a mini-training session for work flows that need additional attention," says Passardi.

Recent sessions have covered verbal consents, sexual assault work flows, insurance review, assigning no-fault insurance, registering a foster child, and insurance websites. Another session used a role-playing scenario to show staff how to conduct a patient interview properly. "We went through a demo of a bad interview session, and then covered a proper one explaining why we need to ask for certain items and what could happen if we miss capturing these items," says Passardi.

This particular lunch and learn targeted a common mistake in the department. Registrars don't always ask for all insurance, when a patient presents. "We can never assume anything. We should always ask," says Passardi. "These errors can hold up a bill from going out, or can generate a denial."

Avoid Future Denials

Often, a change in payer coverage is discovered too late — only after a denial is received. "Once identified, quick communication is needed to avoid future denials, which can be costly," says **Susan O'Brien**, director of patient access at Advocate Good Samaritan Hospital in Downers Grove, IL.

The department is seeing more frequent changes from payers. No coverage can be taken for granted. "You can no longer predict what services will be covered and which will be denied," says O'Brien.

O'Brien uses a wide variety of communication tools to "ensure the change being communicated is hardwired."

These include email, rounding during shift changes, departmental newsletters, and online training tutorials. "We also create 'hard stops' throughout the day, to answer any questions the associates may have," says O'Brien.

Patient access employees are encouraged to ask questions. "Having a questioning attitude allows them to be confident they understand the change," says O'Brien.

Ensuring that all registration areas, both centralized and decentralized, receive a consistent message can be difficult. "Knowing the most effective communication tool for your audience is critical to ensuring the change is understood effectively," says O'Brien. ■

SOURCES

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Stop Surprise Bills With One Pre-reg Call

Newly created position boosts patient satisfaction

Getting an unexpected bill weeks or even months after a service will frustrate even the most satisfied patient. Preregistration phone calls can prevent this from happening.

"Within my department, I have been able to allocate one dedicated full-time employee (FTE) to call patients and preregister them over the telephone," says **Shelita Russ**, CHAM, director of patient access services at Ochsner Medical Center, Kenner; Ochsner Medical Center, River Parishes; and St. Charles Parish Hospital, all in Louisiana. Registrars call patients two or three days before their scheduled services. "The goal is to get out to five days in advance," says Russ.

The registrar completes the entire registration over the phone. "She

EXECUTIVE SUMMARY

Patient access departments are moving financial discussions earlier in the process with preregistration phone calls.

- Patients appreciate advance notification of what they'll owe.
- On the date of service, preregistered patients are expedited.
- More efficient workflows made it possible to reallocate a full-time employee for preregistration.

also makes the initial request for the patient liability amounts," says Russ.

The following metrics are being tracked:

- the number of preregistration calls placed per day;
- the number of days in advance the preregistration occurs;
- the amount of payment collected over the phone.

"Because this amount has been minimal, we are beginning to track the point-of-service collections from preregistered accounts made on the actual date of service," says Russ.

If the patient pays over the phone and wants a receipt, the registrar informs them their printed receipt will be available when they arrive at the facility for their services. If the patient wants to pay in person, the amount they owe is documented in the system so registrars can collect it on the date of service.

Once the registrar completes the pre-registration, she marks the encounter as preregistered. "The front-desk teams can identify the patient and expedite the registration," says Russ. "We also use the preregistration call to notify patients of any residual balances."

In the near future, the registrar will set up payment plans as well. "Currently, the preregistration process has not greatly impacted point-of-service collections," says Russ. Initially, patients were preregistered only if they were having a screening mammogram.

"As we progressed within the pilot, we incorporated the diagnostic mammograms and began requesting patient liability amounts," says Russ.

Collections have increased, but minimally. Still, patients appreciate being made aware in advance of their liability amounts.

"We expect to see a more notable increase once we incorporate the MRIs and CTs into the preregistration process," says Russ.

Greater Satisfaction

In the three months since the new preregistration process started, Russ has seen no evidence of poor patient satisfaction. In fact, the opposite is true. "We have found that patients really like the advanced notification of their liability amounts, and also the opportunity to fast track the registration process," Russ explains.

> COLLECTIONS HAVE INCREASED, BUT MINIMALLY; STILL, PATIENTS APPRECIATE BEING MADE AWARE IN ADVANCE OF THEIR LIABILTY AMOUNTS.

Patient access chose to pilot the new process in the mammogram area specifically because patient satisfaction scores had dipped in early 2017. "We have seen the standard registration score go from the 37th percentile to the 94th percentile so far," Russ reports.

Since mammograms are scheduled for every 15 minutes, preregistration has improved patient flow greatly. "It has reduced bottlenecks in the department," says Russ.

Satisfaction with wait times have increased from the 63rd percentile in the beginning of 2017, to the 99th percentile on the organization's PressGaney surveys.

The department plans to implement the preregistration process in other diagnostic areas. "We plan to incorporate MRI, CT, and ultrasound patients into the preregistration process," says Russ.

No additional FTEs were needed for preregistration. "We streamlined a few workflows within the inpatient registration area," Russ says.

The biggest efficiencies were discovered with the authorization process. Staff were not using the payer portals as expected.

"Once we streamlined that process and staff spent less time on the phone, management was able to incorporate additional tasks into the teams' day-to-day workflows," says Russ.

These changes also made it possible for the department to reallocate an FTE for preregistration.

"As we continue to become more

efficient in our workflows, we have identified the potential to be able to re-allocate another FTE within the next few months," says Russ. ■

SOURCE

- **Shelita Russ**, CHAM, Director, Patient Access Services, Ochsner Medical Center — Kenner, Ochsner Medical Center — River Parishes, St. Charles Parish Hospital. Phone: (504) 464-8026. Email: sruss@ochsner.org.

Scanning Palm Veins or Irises? Patients Will Come to Expect It

A growing number of patient access departments are turning to biometrics to identify patients, by implementing iris scanning or palm vein scanning technology.

Zachary Rogers, a principal in the Minneapolis office of Deloitte Consulting, notes that some organizations have used the recent focus on integration of electronic systems in the clinical and revenue cycle areas to drive other technology investments. This includes patient identification.

Some hospitals did not have a single, clean Enterprise Master Patient Index (EMPI), for instance. Many organizations recently have improved or created their EMPI through an electronic health record implementation.

"Some used the implementation as an opportunity to invest in biometric scanning technology, thus reducing the patient duplication rate to almost zero vs. an industry average of about 8%," says Rogers.

Rogers estimates that currently, less than one-third of hospitals have either palm vein or iris scanning in place. As for whether palm vein or iris scanning is preferable, Rogers says both versions have tradeoffs. Both are more accurate than fingerprint scanning.

"Palm vein scanning is the fastest growing area of biometric identification. It's capable of minimal to 'no touch' authentication, and is less expensive than iris scanning," says Rogers.

Iris scanning is more prone to authentication errors, such as if the patient looks away during the scan. "It typically requires more upfront explanation with the patient," says Rogers. "Not everyone feels comfortable putting their eye up against something they're not familiar with."

Whichever tool is chosen, patient access needs a well-thought out strategy on how to communicate the change to patients.

"Patients should understand why the technology is getting implemented," says Rogers. "It should make them feel safe that their identity is protected."

Determine Return on Investment (ROI)

Evidence of cost savings will help patient access leaders justify the investment to hospital administrators. "It is important to come up with your intended ROI," says Rogers.

Duplicate medical records is one area of considerable savings. "A lot of organizations dedicate significant resources to merging of duplicate medical records," notes Rogers. Since implementation of palm vein or iris scanning has been shown to reduce duplicate medical records, FTEs can potentially be reallocated. "It also cuts down on identify theft and bad debt," adds Rogers.

Although the majority of patients are comfortable with the new technology, not all are. Policies and procedures also are needed for what to do if a particular patient chooses not to utilize the new technology.

"Think through what to do if a patient opts out," says Rogers. "You need to be sure your staff are ready, just as if you were rolling out kiosks or anything else in the patient access arena."

EXECUTIVE SUMMARY

Registration areas increasingly are using iris or palm vein scanning. Before implementing this technology, patient access should consider the following:

- How to communicate the change to patients;
- The need for patients to understand that the technology will protect them from identify theft;
- What to do if patients want to opt out.

Patients typically are satisfied with palm vein and iris scanning, however. Rogers predicts patients will get used to the new technology quickly and even come to expect it in registration areas.

"Think about the airline industry. We all hated those kiosks when they first came out," says Rogers. "Now we get frustrated if a kiosk isn't available and have to wait in line to speak with a customer service rep." ■

SOURCE

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Future Patient Access Leaders Learn on the Job

Give registrars 'stretch' assignments to boost leadership skills

Formal classroom training is one way for patient access employees to hone their leadership skills, but it's not the only way. "People learn in many ways," says **Medha Havnurkar**, FACHE, CPHQ, director of talent management, organizational effectiveness, and culture at Edison, NJ-based Hackensack Meridian Health.

The "70:20:10" formula holds that people acquire about 70% of learning through on-the-job experiences, 20% through coaching and feedback, and just 10% from formal training programs.

"Creating unique, enriching on-the-job experiences to build leadership skills can be done creatively and economically," adds Havnurkar. Below are some recommendations to train future patient access leaders.

• Assess the employee's current leadership skills and abilities.

"This should include the employee completing a self-assessment, and the direct manager completing a manager assessment on the employee's current observable leadership skills," says Havnurkar.

Comparing the two assessments establishes a "baseline" of the employee's key strengths. "This awareness could be enriched by seeking feedback from peers or from key internal or external customers that the employee has been interacting with on a regular basis for at least six months," says Havnurkar.

• Build a supportive, open culture with lots of coaching and feedback.

"Patient access leaders should be modeling this receptiveness by themselves, constantly seeking feedback and being willing to offer feedback upon request," says Havnurkar.

• Use publicly available content on leadership skills.

"In the current digital age, there are volumes of excellent books, articles, and videos that share rich information on leadership skills," says Havnurkar.

To instill a "learning mindset," Havnurkar suggests sharing links with employees, then asking them to come prepared to discuss the material at the next staff meeting. "Ask other high-performing leaders in other parts of your organization to share their favorite books, blogs, or videos on leadership," suggests Havnurkar.

• Invite these leaders to come and talk to your employees over coffee or lunch.

"Most mature leaders do oblige as they see value in sharing their expertise," says Havnurkar.

• Connect promising employees with experienced mentors.

Building a pool of "mentors and mentees" in the organization can expose promising employees to other high performing leaders. "This allows organizations and patient access leaders to build engagement and retain their high performers," says Havnurkar.

EXECUTIVE SUMMARY

Creating on-the-job experiences can build leadership skills of patient access employees. Below are some proven approaches.

- Connect promising employees with experienced mentors.
- Ask employees to serve interim leadership role for defined periods of time.
- Encourage employees to act as team lead on a project.

CREATING UNIQUE, ENRICHING ON-THE-JOB EXPERIENCES TO BUILD LEADERSHIP SKILLS CAN BE DONE CREATIVELY AND ECONOMICALLY.

'Stretch' Assignments

Giving employees a "stretch" assignment is one of the best ways to boost their leadership skills, says Havnurkar. Employees can serve in an interim leadership role for a defined period of time, or act as team lead on a project.

"These experiences should be supplemented by timely coaching and feedback by an experienced leader at appropriate intervals," says Havnurkar.

Patient access employees with leadership potential can:

- be a training facilitator to teach an onboarding module to new employees;
- be part of a pool of facilitators rolling out a new organization-wide initiative, such as customer service;
- participate on committees totally unrelated to their job, such as planning employee recognition programs or quality improvement teams.

"This allows patient access employees to interact, observe, and work collaboratively with team members and leaders from other departments," says Havnurkar.

In the current healthcare environment, mergers and acquisitions happen on a regular basis. So Havnurkar suggests giving this "stretch" assignment to a promising patient access employee.

- Find out the acquired hospital's current patient access department processes.
- Create a side-by-side comparison on the similarities and differences between the two organizations' processes.
- Draft a set of recommendations on how the integration can be approached for a smooth transition.

"Most organizations' training departments are quite lean," notes Havnurkar. "Training teams would gladly help to put patient access employees through train-the-trainer programs that might exist." ■

SOURCE

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