FOR MORE THAN 30 YEARS

HOSPITAL ACCESS MANAGEMENT™

ADMITTING + REIMBURSEMENT + REGULATIONS + PATIENT FINANCIAL SERVICES + COMMUNICATIONS
GUEST RELATIONS + BILLING & COLLECTIONS + BED CONTROL + DISCHARGE PLANNING

INSIDE

RELIAS
Formerly AHC Media

JULY 2018 Vol. 37, No. 7; p. 65-72

Self-service Options Coming to Patient Access?

Many Americans have become accustomed to self-service options for online shopping, booking airline tickets, making hotel reservations, and even paying phone and utility bills. In sharp contrast, patient access processes are starting to seem terribly outdated.

"Patients desire similar experiences with their healthcare payment needs," says **Gordon Jaye**, vice president of hospital operations at Patient Matters.

Other self-service experiences are known and loved for their simplicity and consistency. Understandably, patients want the same when it comes to registration, physician referrals, scheduling, and bill payment.

"Patients are beginning to wonder why they need to interact with anybody as they perform a full registration and financial clearance," Jaye says.

Healthcare is notoriously slow to react to change, and self-service is certainly no exception.

"It can take hospitals time to come around. Self-service is very much in the early stages," says **Jason Considine**, senior vice president of patient collections and engagement for Experian Health. One barrier to self-service is surprisingly simple: Many patient access departments lack permission to communicate with patients via cellphones.

"When we interact with self-service tools elsewhere in our lives, there's an opt-in process we go through as a consumer," Considine explains. "Hospitals lack that entry point."

Most patient access departments are not communicating in any way with patients through phone apps for this very reason.

"Many [apps] have very low use rates, even on their patient payment portals," Considine notes.

Obtaining consent to communicate through a website or mobile device is an important first step.

"It is a gate that people have to get through," Considine says. "It's an investment in building an electronic relationship with the patient."

Changes in consent policies and the paperwork that patients sign are needed. "Many hospitals, believe it or not, we find, aren't collecting email addresses or cellphone numbers from patients," Considine notes. This is because outdated registration systems don't contain those fields. Therefore, there isn't

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management™ (ISSN 1079-0365) is published 12 times annually by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518-9238

Periodicals Postage Paid at Cary, NC, and additional mailing offices.

POSTMASTER: Send all address changes to:
Hospital Access Management
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518-9238

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
CustomerService@AHCMedia.com
AHCMedia.com

SUBSCRIPTION PRICES:
Print: 1 year (12 issues): $429. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $379
Outside USA, add $30 per year, total prepaid in U.S. funds

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

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.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Terrey L. Hatcher

any reason for patient access to enter this contact information.

"If you don't have the data, it's starting from scratch to build the ability to do this," Considine says. Unlike retail shopping, healthcare reimbursement is complex, private, and highly personalized.

"There are impediments to the widespread use of technologies in the healthcare revenue cycle that support this level of consumerism," Jaye explains.

Hospital systems don't support the data validation that online shopping merchants use to conduct business. "This causes issues on the back end with claim processing," Jaye says. Problems also occur on the front end. Sometimes, insurance information is not validated, or authorizations are missed.

"The gap here is that there are lags in the system and data integration between HIS legacy systems and many of the traditional front-end systems," Jaye notes.

This is going to take some time to overcome, but change is underway.

"We're beginning to see patient-friendly price estimations, where patients can go on to provider websites and run estimations for themselves," Jaye says.

Patient Access, Redeployed

Future patients will handle more of the registration work themselves.

"Staff will check out those who are the exception," Considine offers.

This will allow patient access staff to perform higher-level activities.

"They can redeploy staff to tackle some things that were going unnoticed," says **Jason Wallis**, senior vice president of patient access for Experian Health. Staff can turn their attention to accounts at high risk of going uncollected, claims denials, or upfront collections. All these activities emphasize creating a positive experience for the patient. The rise in healthcare consumerism is the driving factor behind all these changes, according to Wallis.

"Before, the patient would just show up at the hospital that was closest to them."

Once self-service is commonplace, patient access will take on more of a customer service role. Wallis expects registration areas to be redesigned as a result of this shifting role. These areas might seem more like hotel lobbies than waiting rooms.

"Access is moving from 'Let's get the data we need, and you go sit in the waiting room,' to looking at the level of greeting, to making sure you have a good experience," Wallis says.

Even with self-service, there still will be a need for face-to-face interactions with patient access staff.

"We have yet to see a successful deployment of a registration process that is completely automated without any interaction on the hospital side," Jaye notes.

This would be potentially dangerous, since multiple registrations could be created for the same patient.

"The ideal situation would be a more, but not completely, automated registration process," Jaye says.

Checks and balances always will be needed to prevent errors and identity fraud. In this regard, the patient access version of self-service has something in common with the self-checkout line at the grocery store.

Even though the customer has all the tools to complete his or her transaction, says Jaye, "there is a high percentage of time that a human must intervene and correct a human user error." ■

Communication, Not Computer Expertise, a Must-have Skill for Patient Access

Not too long ago, some basic computer skills and the ability to collect demographic information were pretty much all that was needed for a patient access employee to succeed. Now highly skilled at upfront collections, financial discussions, and customer service, their role continues to expand both in scope and complexity.

"In the future, patient access will be expected to provide a personalized financial care plan, just as the clinical staff provide a clinical care plan," says **Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy at Healthcare Finance Management Association in Westchester, IL.

To perform their jobs, patient access will need a keen understanding of insurance eligibility, benefits, and managed care contracts.

"Consumers are shopping for services, based typically on price and quality," Wolfskill notes.

Quality information is readily available online. However, the amount of money a patient is going to pay for a specific service remains a frustrating mystery for many. In turn, this drives dissatisfaction.

"Gone are the days when posting charges or providing charges as a proxy for the price would be acceptable," Wolfskill says.

Today's consumer wants much more than general information on cost. The new expectation: Patient access can take the hospital's internal charge data, apply the consumer's services, benefits, and the payer's discount, and calculate a patient's out-of-pocket cost. And if they can't?

"There is a very high probability that the consumer who wants to know the price before receiving the service will migrate to the provider who *can* provide that information," Wolfskill cautions. Most patient access departments can provide a reasonably accurate price estimate, assuming the right technology is in place.

"But it is essential to train staff to appropriately *use* that technology — and how to effectively communicate with the patient about the results," Wolfskill says.

BY SERVING AS THE PATIENT-FACING SEGMENT OF THE REVENUE CYCLE, THESE EMPLOYEES CAN MOVE THE DIAL TOWARD GREATER SATISFACTION.

To do this, according to Wolfskill, the patient access representative of the future will need a much more robust understanding of insurance benefits, and how these affect payment; payer contracts, and how they're applied to a specific service; and how claims are adjudicated.

Wolfskill gives this example: A patient has a commercial plan that receives a 27.5% discount off charges. The plan has a $2,000 deductible, after which the plan pays 80% of the discounted charges, with the patient responsible for 20%. There's a maximum out-of-pocket cost of $6,000. If the patient already met the deductible, and $500 of the out-of-pocket cost, what's the patient going to owe — and why?

"We have software to do the math in many organizations, but explaining it to the patient is critical," Wolfskill stresses.

Scenario-based interviewing is one way to identify great communicators in potential new patient access hires. Wolfskill shares these tips:

- Provide a specific situation, and then ask the candidate how they would handle it;
- Direct multiple team members to conduct the interviews;
- Ask open-ended questions to encourage dialogue;
- Listen carefully for candidates using words and phrases that would make sense to a patient.

"Or, do they speak in the acronyms of 'hospital-speak,' which is often not understandable to patients?" Wolfskill asks.

These important new skill sets are one way to measure the increasing clout of patient access.

"Organizations are recognizing that in many ways, patient access positions are becoming equal to — or even more complex — than patient accounting positions," Wolfskill says.

By serving as the patient-facing segment of the revenue cycle, these employees can move the dial toward greater satisfaction.

"If organizations put their best and smartest employees in those patient access roles, the payoffs are many," Wolfskill predicts.

Two very important examples for the revenue cycle: fewer claims denials and faster payment.

"There is also improved satisfaction, because the patient understands their bill in advance," Wolfskill adds. ■

Online Tools Shed Some Light on Out-of-pocket Costs

How much will it cost? It's a surprisingly complex question, and the ability of patient access employees to answer it is becoming increasingly important. Concurrently, new online price comparison tools are appearing everywhere; yet, those tools carry questionable value.

"There are several limitations to current price shopping tools," says **François de Brantes**, MS, MBA, senior vice president of the commercial group at Norwalk, CT-based Remedy Partners. Some recent developments:

• Some nonprofits offer state-focused pricing information based on data from insurers. The Maryland Health Care Commission recently unveiled a website allowing people to compare costs of four common procedures, revealing wide variation in charges.

"It's not a comprehensive shopping resource — at least not yet — but it serves an important purpose," says **Ben Steffen**, executive director of the Maryland Health Care Commission. This is to educate consumers that price and quality vary, sometimes substantially, at hospitals throughout the state. For example, the site's data show that hip replacement differs by up to $20,000 depending on the hospital. "Our goal is to encourage providers, insurers, and employers to work together to make prices more widely available to the public," Steffen says.

• More states provide pricing information based on databases of insurance claims. Other comparison sites are following suit, including AHRQ.gov, BetterDoctor.com, HealthGrades.com, DrScore.com, and other academic or commercially driven websites.

• Increasing price transparency is part of an agenda for transforming U.S. healthcare into a more competitive, value-based system that costs less, Health and Human Services Secretary Alex Azar announced recently.[1] Pricing transparency is "one of Secretary Azar's signature initiatives, and he is pushing hard for hospitals to report prices to the public," de Brantes says.

About half of patients have tried to discover the cost of healthcare before going to get care, according to a recent survey. However, 63% of respondents said there wasn't enough information available.[2]

• There are an increasing number of reference pricing programs, which use financial incentives to encourage consumers to shop for healthcare based on price and quality. "These will place a significant burden on the consumer to understand healthcare prices in advance of using services," de Brantes says.

Price comparison shopping tools represent a symbolic step toward providing consumers with data to inform their healthcare decisions. "But the affect so far has been uninspiring. The vast majority of consumers do not use them. Those who do typically do not spend less," says **Sally Rodriguez**, chief of staff at the Washington DC-based Health Care Cost Institute (HCCI).[3] Here are some common issues with existing tools:

• Only the price of individual services are listed, not the entire episode of care. "That can lead to potentially bad decisions," de Brantes says. Patients can see only a portion of their total costs.

"While procedure-specific costs are easier to calculate, cost estimates for episodes of care are more meaningful to patients," Rodriguez says. This is because healthcare events typically comprise facility and physician fees for multiple services. Therefore, price comparison tools "may not provide a full picture of what patients can expect to pay," Rodriguez adds.

• Only average prices, or average charges, are listed. "Neither of these provide the consumer with a reasonable estimate of the actual price that will be paid," de Brantes offers. It really says nothing about the specific out-of-pocket portion for which the plan member will be responsible.

• The tools are buried in organizations' websites and difficult to find. "One of the more important barriers for all these tools is getting the tool to the consumer at the right time and the right place," de Brantes says.

• The tools are difficult to navigate. Patients are forced to choose from a list of highly specific procedures corresponding to CPT codes. "With so many options and little explanation of their intricacies, even the savviest consumers may struggle to correctly find the procedure they will be receiving," Rodriguez says.

• Only charge data are provided, which doesn't account for negotiated prices. "Charges bear little resemblance to the amount paid by both the patient and the insurer," Rodriguez notes.

Even prices calculated from negotiated prices can be potentially misleading. For many price comparison shopping tools, the price is an average or median price for a given service and provider.

"However, the amount that an individual can expect to pay for a given service or episode of care at a facility may vary greatly depending on that patient's insurer and benefit design," Rodriguez adds.

• Only facility fees are posted, which doesn't include physician fees.

Provider-specific estimates can vary widely based on the payer's negotiated rates for in- vs. out-of-network providers. Benefit design information becomes critical here. "It dictates what out-of-pocket spending is likely to be and, importantly, whether specific providers are in their network," Rodriguez explains.

What would be *really* meaningful to patients? According to Rodriguez, "Only price shopping tools that offer provider-specific estimates of out-of-pocket spending, based on an individual's current insurance benefit design."

With growing momentum toward price transparency, there are signs of legislative change on the horizon. This is happening both at the state and federal level. "Some members of Congress appear to be interested in price transparency as part of a broader focus on healthcare affordability," Rodriguez says. HCCI recently responded to a bipartisan group of senators' request for input to help them develop legislation to improve price transparency.[4] Some key recommendations:

• There is a need for improved national standards in how price and quality information is collected, calculated, and presented to consumers. This includes agreed-upon definitions of concepts such as price, out-of-pocket price, and cash price.

• National and state all-payer claims databases can play a key role in promoting price and quality transparency, but they require additional federal funding and support to do so.

• The federal government should relax restrictions on the use of already-available data, and work to make additional data more available.

"Perhaps the more likely arena for action on transparency is at the state level," Rodriguez suggests, noting that several states are considering transparency-related bills.

HCCI is creating a facility-level price transparency tool for Florida. "Seven states already operate a variety of similar tools, including New Hampshire, Maryland, and Colorado," Rodriguez adds.

Soon, de Brantes expects to see an increase in the number of states adopting all-payer claims databases, increasing focus on price transparency, and better tools. "We'll see what we have seen in all other industries when consumers are the decision-makers," he says. "Applications will be developed and deployed in such a manner that makes them very useful and valuable to consumers." Steffen expects to see more states providing cost and quality websites. "We'll see consumers become more aware of why the cost matters to them in terms of their premiums and out-of-pocket costs," he says.

As patients become more engaged and aware, hospitals with significantly higher prices will have to consider their costs more closely. "It won't happen overnight, but that's where this movement is headed," Steffen adds. As for patient access employees, de Brantes says they'll need to be conversant in the terminology used on the price comparison sites. For example, some patients will want explanations of language such as "episodes of care" or "healthcare events." Patient access also needs to keep in mind that patients are coming from a different perspective. They'll want to know more than just the hospital charges. "Patients need a comprehensive understanding of *all* the costs associated with a procedure or inpatient stay," de Brantes says. ■

REFERENCES

1. Azar, AM. Remarks on value-based transformation to the Federation of American Hospitals. Delivered March 5, 2018, Washington, DC. Available at: https://bit.ly/2I4h3w7. Accessed June 1, 2018.
2. Schleifer D, Silliman R, Rinehart C. Still searching: How people use health care price information in the United States, New York State, Florida, Texas, and New Hampshire. A report by Public Agenda, April 2017. Available at: https://bit.ly/2J7uXgW. Accessed June 1, 2018.
3. Desai S, Hatfield LA, Hicks AL, et al. Offering a price transparency tool did not reduce overall spending among California public employees and retirees. *Health Aff (Millwood)* 2017;36:1401-1407.
4. Health Care Cost Institute. Letter to Congress, March 23, 2018. Available at: https://bit.ly/2sulusY. Accessed June 1, 2018.

Patients Want Services on Demand

Need a CT scan? Brace yourself for making time-consuming phone calls to schedule it and enduring lengthy waits at registration. Or maybe not. Patient access departments are changing their ways due to rising expectations for on-demand care. Clinics and outpatient service areas at Ochsner Medical Center - North Shore in Slidell, LA, "no longer operate on 'banker's hours,'" says Patient Access Manager **Tammy Flair**.

Instead, appointments are available during extended hours for laboratory and radiology, and Saturdays at outpatient areas.

"We no longer want the after-hour and weekend patients to be processed through with the emergency room patients," Flair says. Physician clinics have followed suit, offering X-rays, ultrasounds, CT scans, and even MRIs during off-hours so that patients don't need to go to the hospital for these services.

"Our patient access team has had great success in this process," Flair reports. The department made several changes to accommodate walk-ins:

• Service areas were expanded by 23 hours per week, with a centralized registration point of entry.

"We needed to provide a professional and non-emergent arrival for improved satisfaction," Flair says.

• Employee schedules were modified to absorb the 23 hours without adding any additional FTEs.

"We found the ability to scale the three FTEs in our centralized scheduling department," Flair explains. Instead of all staff working a 7 a.m. to 5 p.m. shift, a staggered shift was created. One FTE arrives at 12 p.m. to work in centralized scheduling. This employee flips to the front desk from 4:30 p.m. to closing at 8:30 p.m. Lower patient volumes during these evening hours create time for registrars to work on other tasks. These include finishing pre-registration calls and helping patients with wayfinding.

"Scheduling teams are focused on filling the prime spots to serve the waiting patients," Flair notes.

If the "add-on" patients see Ochsner physicians, it makes things much easier. This is because all the licensure information already is validated and updated in the system.

"But as long as the physician order meets the mandatory requirements, and we confirm their NPI [National Provider Identifier] status, the patients can be served," Flair says.

• To ensure reimbursement, additional skill sets are required of all patient access employees. All registrars now have access to insurance websites so they can see authorization requirements for each payer. "This information is shared with the physician team to determine medical necessity," Flair says.

• All frontline staff were trained in scheduling. This expedites patient arrival and registration considerably, making things go much smoother.

"We cannot afford any unnecessary delays waiting on a radiology tech, or the main scheduler to assist," Flair says.

• Radiology schedules have been modified to fit availability. The schedules have been analyzed and formatted carefully so that the test duration matches the appointment times.

"If there are two techs available for a particular service, such as CT scan vs. mammogram, then two schedules were created," Flair says.

• A "one-stop shop" has been designed. Now, any point of entry for patient access can complete an arrival. This includes check-in, scheduling, verification, and financial coordination. All team members are cross-trained in the clinics, outpatient departments, the ED, and surgery areas. Now, they can register any patient type.

"Their vast knowledge of insurance benefits and authorization determination allows us to successfully meet the needs of walk-in patients," Flair explains.

Ochsner's pre-service team verifies benefits, creates a price estimate, and starts the referral or authorization process.

"This department works these cases as soon as the order is created, or if a patient presents to the facility with an order," Flair says. These steps occur:

1. The walk-in patient arrives with an order, or the order is faxed over as a "stat," and is approved;
2. The registration team reviews the schedule and books the appointment, or requests help from centralized scheduling;
3. The insurance card and face sheet are given to the insurance verifier, who starts the process of determining if an authorization is needed;
4. The preservice department educates the patient on their benefits, and provides a price estimate;
5. If authorization is delayed for any reason, then medical necessity is determined by the physician. Payers sometimes require several days to give the authorization, which means it can't be obtained in time.

In such cases, says Flair, "Our priority is giving the patient the care they need. We take the risk when the physicians confirm medical necessity." Meanwhile, the team continues working on authorization retroactively to ensure proper reimbursement is obtained. "If authorization is required and pended, calls are made to the physician team for critical clinic notes and confirmation of urgent necessity," Flair says.

6. If the test isn't urgently needed and authorization is delayed, it's scheduled for a future date. Patients are offered after-hour and weekend appointments for convenience. The case is monitored by onsite teams until the authorization gets approved. Throughout the process, the patient is kept updated on the status of things by phone. "It literally is a stop, drop, and roll function to make sure the patient's needs are met," Flair adds. ■

Accommodating Walk-ins? Don't Forget Scheduled Patients

Walk-in outpatient services have been around for years. "But the culture has evolved into this being more the norm," says **Stewart Rasberry**, MBA, manager of patient access, registration, and the revenue cycle at St. Bernard Parish Hospital in Chalmette, LA.

Hospitals are capitalizing on this trend. "For competitive market growth and patient satisfaction, there has been heavy promotion of same-day services," Rasberry notes. Steady growth in the volume of walk-ins is the predictable result. Additionally, many hospital mission statements emphasize that patients are the number one priority, which is consistent with same-day services. St. Bernard Parish Hospital is part of the Ochsner Health System, which defines its core values as "Patient First, Compassion, Integrity, Excellence, and Teamwork."

Servicing the growing population of walk-in patients and expanding hours to evenings and weekends "are just the next steps in a patient-first mentality," Rasberry adds. Accommodating both scheduled and walk-in patients is a challenge for patient access departments trying to meet the needs of both groups. St. Bernard Parish recently expanded service hours due to pressure to accommodate patients wanting same-day services, mostly for lab work and radiology. "Over 50% of our outpatient volume is from walk-in patients," Rasberry reports.

Previously, services were only available Monday through Friday from 8 a.m. to 5 p.m. Now, earlier and later hours are offered on weekdays, starting at 5:30 a.m. and ending at 7 p.m. Saturday hours are 8 a.m. to 5 p.m. "Demand for after-hour or weekend appointments is due to a shift of both parents being in the workforce, and older persons having delayed retirement years," Rasberry says.

The biggest challenge with walk-ins? The effect they have on scheduled patients. For instance, if 10 mammogram appointments are available on a given day, and all are filled with scheduled patients, there are no slots available for walk-ins. "Department workflows must be flexible to accommodate the same-day requests in an equally timely manner," Rasberry says. To accomplish this, schedules make allowance for walk-ins. "Of course, if you have multiple walk-in patients for the same service at the same time, this has a ripple effect throughout the day on seeing the scheduled patients on time," Rasberry cautions. All patients are seen in a timely manner. However, some scheduled patients end up receiving service slightly after their scheduled appointment time. This all depends on the number of walk-ins on a given day. On a day with few scheduled patients, some registration staff might be reallocated to other areas by the middle of the day. "We utilize the reallocated staff for pre-registration of the future scheduled patients," Rasberry says.

This helps expedite their check-in event and best prepare for the other walk-in patients. "If there is a large volume of walk-in patients that afternoon, it is difficult to service the patients," Rasberry acknowledges. Inpatient workflows also have been affected. Departments such as radiology and the lab have to balance servicing hospitalized patients with walk-ins. Still, Rasberry describes expanded hours of operation as a "win-win." Patients win because more available appointments means easier and quicker access, and patients don't need to miss work. The facility wins by seeing more patients in a day. "This increases patient volume and revenue," Rasberry adds. ■

Surprise Bills 'No Longer Acceptable' to Savvy Patients

As collections continue to move to the "front end" of the revenue cycle, patient access is expanding pre-service processes. Loma Linda (CA) University Medical Center's pre-service collection department calls patients ahead of time. "They are quite successful in collecting over the phone when they do the educational piece beforehand," says Admitting Director **Denise Rotolo**. Employees verify demographics, inform patients of their

benefits and estimated liability, and try to collect the amount due. This prevents patients from receiving a surprisingly large bill on the date of service.

"Even though everyone should know what their insurance is, most of the general public does not," Rotolo says. "They assume they've got great coverage because they have insurance."

The department has been working on point-of-service collections since 2005.

"Probably in the last three to five years, we've really come to maturity," Rotolo reports. From 2014 to 2016, point-of-service collections increased by 14%. "Most of our patients understand they have a liability. They expect us to have that discussion with them," Rotolo says.

Soon, the financial services department will engage in similar conversations.

"They are training to make phone calls to patients after they have verified benefits, authorization, and liability," Rotolo says. "This will be in addition to my pre-service team."

Educator Role

Mary Lee DeCoster, a Phoenix-based revenue cycle consultant, says that, ideally, patient access handles scheduling, financial clearance, pre-registration, and, ultimately, registration.

"Patients want to know 'How much do I owe?' prior to service," she underscores.

The historic process of waiting for the bill after service has been provided, complete with the surprise factor, "is no longer acceptable for today's savvy healthcare consumer," DeCoster cautions.

Collecting at the time of service allows hospitals to reduce bad debt and stabilize cash flow. It also gives patients the information they need to decide if they wish to proceed with care and to put financing plans in place if necessary.

"Successful hospitals are collecting as much as 50% of the total out-of-pocket for scheduled patients," DeCoster reports.

With higher out-of-pocket costs for patients due to high-deductible plans, patient access is taking on two important new roles: collector and educator. Today, these are two must-have skill sets in the patient access field. Both require excellent communication competency.

"Employees within patient access have the training and knowledge to provide meaningful education to patients," DeCoster says.

Patients need information on insurance benefits, coverage, and options for payment. This all can be covered during a pre-service call, but only if staff are well-prepared to engage in this complex financial conversation. DeCoster says that before a discussion occurs, patient access should know whether an authorization is on file, the patient's propensity to pay, and a detailed price estimate.

"Armed with this information, the financial clearance rep can provide education to the patient regarding their financial obligations," DeCoster offers.

At this point, patient access can request full payment or a deposit, make payment arrangements, or refer the patient to someone who can assist with a Medicaid or charity care application.

"This step ensures there are no surprises — for the patient *or* for the hospital," DeCoster notes.

When a new upfront collection process is rolled out, patients typically resist. Many argue, "I've never been asked to pay upfront in the past."

"Robust scripting for financial clearance staff, provided during training, should mitigate community perception," DeCoster says. ■

HOSPITAL ACCESS MANAGEMENT™