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'What We Do Matters to People': The Importance of Making Positive Impressions

Every patient access leader wants impressive satisfaction scores to share with hospital leadership. But unlike clinical areas, they face a daunting obstacle. Most people do not quite comprehend the patient access role, which encompasses registration, scheduling, and more, all conducted in many hospital settings. For this reason, Press Ganey survey results can be somewhat misleading.

"Patients often are not equating registration to a tangible service we are providing to enhance their visit," explains **Tiffanie Ball**, patient access director at Rochester (NY) Regional Health (RRH). Patient access addressed this problem in several ways:

• **All registration staff now wear blue scrub tops.** "We purposely picked a color very different from what clinicians are wearing, so they stand out," Ball says, noting this is a practice at all four hospitals in the RRH system. "This helps people to connect the job of patient access with the questions on the Press Ganey survey."

• **Staff use words similar to the survey questions.** The department began to focus on the patient experience several years ago. At that time, RRH Press Ganey scores were much lower, despite registrars giving good service. "We attributed this to patients not truly understanding which group was indicated in these questions," Ball notes.

The questions ask about "courtesy of the registration team member," "ease of giving your personal insurance information," and "privacy during giving personal insurance information."

Patient access leaders worked on scripting to help patients connect the helpful registrars with whom they interacted to these survey questions. "Having team members utilize the same verbiage as the questions aided in raising our score," Ball says.

For instance, staff state, *"My name is Tiffanie. I'm going to complete your registration and update your demographics and personal insurance information."* Ball says this message is uniform across the four RRH hospitals.

Sometimes, patients marked a low score on the question about whether the hospital provided privacy, without completely realizing what that means. Registrars in the ED state, *"I'm going to close this curtain so the information you provide is private."* The hope is that people will remember their privacy was respected when

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they complete the survey question on this point.

A barrier to satisfaction in a hospital's busy ED involves timing. Many people are highly stressed and sometimes in pain when the registrar approaches. If registrars notice this, they say, *"I see you are not feeling well. I can come back at a later time."* This approach stresses the "courtesy" mentioned in the survey. "[Registrars] can come back in 10 or 20 minutes instead of forcing the registration at that time," Ball says.

Press Ganey scores are very important to the RRH organization. However, these scores do not tell the full story about patient access. For this reason, RRH's patient access leaders created their own targeted survey for patients to complete right away using these questions:

- How friendly was the person completing your registration?
- Did they ask you for your primary care physician and update if it had changed?
- Did they explain the documentation you signed? Did you receive the Bill of Rights?
- Did they ask for your insurance card? If applicable, how did they ask for or inform you of your copayment?
- How would you rate your interaction with registration on a scale of 1 to 5?

Patients can hand the short survey to anyone wearing blue scrubs or drop their responses into a box as they leave the hospital. Patient access leadership has found this particularly helpful if satisfaction scores are dipping in a certain registration area.

Sometimes, Press Ganey scores are much lower than expected. RRH's custom surveys help clarify what is really happening. "We have found those scores are much higher than our Press Ganey scores," Ball reports. There is growing awareness that the first impression at registration sticks with a person throughout their entire hospital encounter. This realization is of great importance to patient access.

"For every patient, regardless of what service line they are seeing, patient access is going to be part of their visit," Ball notes. The repercussions of registration, whether positive or negative, stick with people. "Ensuring this team is engaged in providing the best patient experience is how we are able to maintain a healthy system," Ball says.

Traditionally, when hospital leaders thought about patient satisfaction, medical outcomes were top of mind. Registration was not considered at all. "Historically, when we thought of patient experience, we discussed the clinical care our patient was receiving," Ball explains.

With the greatly expanded role of patient access, the idea of what patient satisfaction covers also has expanded. The problem is that most of the biggest dissatisfiers are unavoidable. One of these is wait times. Even the best possible planning, adequate staffing, and great training cannot change the inevitability of waiting. Of course, service delays and other unplanned events can exacerbate this reality. In this all-too-common situation, Ball says it is often the little things that count. "We have incorporated rounding in our waiting areas," she reports. Registrars ask two questions: *"How are things going?"* and *"Is there anything I can do for you right now?"*

Receiving a blanket in a cold waiting area or a glass of water (registrars check with clinicians first to be sure it is medically permissible) can help patients feel they are not forgotten.

Calling attention to hard-won evidence that patient access at RRH is handling the patient experience well is an absolute must. "We huddle daily with our group around our visual management board," Ball says.

Key Performance Indicators are the main topic of discussion, with a strong emphasis on satisfaction. The latest scores are posted in the department so everyone is keenly aware where things stand. However, the process does not stop there.

"We then do a look back and discuss actions that aided in higher scores," Ball explains. "For the times that we fell short, we are able to identify barriers that may have hindered our goal."

High Press Ganey scores do not reach individual registrars, unless someone takes the time to write in comments pertaining to a certain employee. For this reason, great service is spotlighted in other ways. Recently, a patient received an unexpected phone call while awaiting an ED inpatient bed. The call was not from a friend or family member, but from a representative from his health plan. The payer representative warned that the visit could be denied, leaving the patient on the hook for the entire bill. At first, the worried patient was inclined to leave the ED, but a quick-thinking registrar intervened.

First, the registrar assured the patient she would look into his situation immediately. She consulted with the billing department, then came back to the waiting patient. The registrar explained that even if there was a denial, which was by no means certain, the hospital would intervene on the patient's behalf. She added that the hospital had successfully overturned other similar denials.

"The patient was very grateful that the registration staff member took the time to explain what the hospital would do to validate why the patient was there," says Ball, who used the registrar as an example of excellent service at the next staff meeting.

When patient access leaders wish to recognize a registrar who went above and beyond, they do not have to guess what the employee really wants. Each registrar completes an "About Me" form with these specifics. Some want to keep things low key during staff meetings. For these employees, leaders tell the story of their fantastic service without giving away their name. Others really love coffee and receive a $5 gift card to a local donut shop.

The constant emphasis on great service helps with morale. In patient access, says Ball, "we talk a lot about point-of-service collections and denials. This pulls us away a little from the money part of healthcare. It paints a picture: What we do matters to people." ■

Are Patients Happy? If Not, It Might Be Outside Your Control

Many issues come into play with patient satisfaction. Plenty of these are partly, if not totally, linked to other departments. Wait times, clinical care, cleanliness, and billing processes are just a few.

"All of these integrate with the revenue cycle, often behind the scenes, but sometimes fall outside of our control," says **Melissa Patten**, associate vice president of patient access at Northern Light Health in Brewer, ME.

It may be that a patient's elective surgery was rescheduled because of inclement weather — at great inconvenience to the patient. Another patient may have waited five hours in the ED because multiple trauma victims were brought in after a motor vehicle accident. The patients in those two examples may be very unhappy with their hospital experience, but that does not mean the registrar did not perform his or her job well.

"Revenue cycle functions mix financial components into the clinical experience," Patten says, noting that both patients from the previous examples, in addition to their other issues, were asked for thousands of dollars by registrars. "There are sensitive conversations happening during times of illness and injury."

All of this makes it more difficult for registrars to achieve great scores. Consistency can help because people know what to expect. For patient access, says Patten, that means "standardization of workflows and centralization of applicable processes to cater to the knowledge, needs, and preferences of the patients that we serve." Going forward, patient access leaders at Northern Light Health will be giving patients more choices on communication methods. They also will provide patients with self-scheduling in an ever-evolving attempt to boost satisfaction.

Patten has found that some data are especially helpful in pinpointing trends in patient satisfaction. Such indicators include issues like wait times (both at call centers and onsite), the number of claims denials, "no show" rates, point-of-service collections, accuracy of patient estimates, and staff productivity.

"A combination of metrics highlighting both clinical and financial processes produces a holistic view of the patient's satisfaction with their experience," Patten concludes. ■

Successful Collection and a Good Patient Experience? It Is Possible

For virtually every hospital, the patient experience is a top priority. The same is true for point-of-service collections. For patient access, this presents quite a conundrum. The question becomes: How can registrars keep patients smiling while asking for money — sometimes, a great deal of money?

For at least one registrar, the answer is some humor. The registrar lists the various payments the hospital accepts: cash, credit, or check — then adds the unexpected comment, *"But no IOUs."*

"Her patients will laugh with her. She is one of the higher collectors for the department," says **Tiffanie Ball**, patient access director at Rochester (NY) Regional Health (RRH).

This successful approach illustrates the limitations of scripting for patient access departments. For those who are uncomfortable even mentioning money to patients, scripting can be quite helpful. However, at times, such scripting comes off as robotic and impersonal. Ideally, says Ball, scripting should "give people a general sense of how to present information to the patient, while adding a bit of their own flair."

High deductibles are increasingly common and often blindside patients who have scheduled outpatient procedures. "It is not uncommon for registration team members to ask for a payment that could be in the thousands of dollars," Ball notes. Many patients are completely unaware of this possibility and are more than a little surprised. This means patient access has to step into the role of teacher. "We find that registration team members are often educating during these difficult conversations," Ball adds.

The situation becomes exponentially more difficult when the patient says he or she cannot pay. "When the patient expresses a financial hardship, we've equipped the team to navigate these delicate conversations," Ball says.

First, registrars connect the patient to the one person who can really help them. At RRH's four hospitals, that individual is a financial case manager. "He or she is able to provide the various resources we have available, including financial assistance and payment plans," Ball says. However, the top obstacle to successful high-dollar collections is lack of good information. "When we first saw this shift, it was a dramatic change in our collecting practices," Ball recalls. "I credit much of our success to the tools we have been able to develop."

It begins with real-time eligibility of the patient's insurance. This tool gives registrars confidence that the dollar amount they are quoting is correct — not because they say so, but because the payer does. "It helps the patient understand that dollar amount we are asking directly correlates with the type of coverage they have chosen," Ball explains. This makes it less likely patients will blame the messenger for their large balance.

Hopefully, registrars can tell patients exactly how much of their deductible is left. "We also have a great patient estimate that is built into our EMR," Ball reports. Price quotes are much more accurate, as these quotes are based on the payer, place of service, CPT code, and other factors specific to the patient. "This takes the guess work out of estimates," Ball adds. ■

Doing More With Less Staff? Cross-Training Is Not Enough

Patient access staff are reallocated as needed at Montefiore Nyack (NY) Hospital — but only if they are equipped with the necessary skill sets. "It is not wise to simply move someone to another location if they have not been previously exposed to the area," says Patient Access Services Manager **Jason Guardado**.

"Cross-functioning" is the term of choice at Texas Scottish Rite Hospital for Children in Dallas. "All too often, you see cross-training being a skill set that is only called on in times of need," says Patient Access Director **Mike Potter**.

Short-staffed registration areas are the most obvious example. Registrars call out sick or are out on FMLA. Suddenly, volumes surge. "You then ask your cross-trained team members to dust off their manuals and do their best," Potter says. Sometimes, this is successful; other times, it is not. The department decided to take a new approach by creating cross-functioning roles that are used all the time. This mirrors the "schedgistration" process used by some departments, which combines registration and scheduling. "One patient access member is used in multiple traditional roles without the concern of rarely used cross-training skills," Potter explains.

Typically, registrars become experts in their particular area, whether

radiology, clinics, or ancillary services. "Certain rules may only apply to that unit," Potter notes.

Accurate registration is not enough to be successful. The registrar has to remember the nuances — and these apply only to a certain area. However, this has changed.

"We have worked with the leadership of many areas to streamline and standardize as many of the registration steps as possible," Potter reports. This increases quality and efficiency.

The department also created competency checklists for every role. "As new duties and tasks are assigned, we train our teams and add the competency to the list," Potter says.

These differ for every role. For instance, calculating adjustments to patients' out-of-pocket costs are part of a financial counselor's responsibility. Registration does not perform this function.

"We take a lot of time training on the competencies. We do not let an employee operate on their own without full signoff," Potter says. Any staff member who floats between areas is required to complete the competency for each area. The checklists cover such tasks as scheduling follow-up visits, adding and removing coverage, updating demographics, and checking referral needs. "These differ from role to role, and we have one for each," Potter explains.

Both the leader and the staff member sign off that they fully understand the requirements. "Any staff member who floats between areas is required to complete the competency for each area," Potter says.

Generally, patient satisfaction is above 95%. Registration wait times are under three minutes. "Much of our success is due to the cross-functioning staff," Potter observes.

Also, morale is noticeably higher. "Our employee engagement is measured and reported internally. Our department metrics surpass the benchmarks provided by the vendor," Potter notes. Since cross-functioning registrars know the big picture of how their role affects the entire team, they know the "why" behind their tasks. "It also gives staff the ability to complete tasks on their own, with less of a need to 'punt' tasks to other areas for completion," Potter says.

The department's error rate, tracked by an internal QA process, has decreased significantly. "When there are fewer errors, you have happier downstream departments, happier patients, and happier employees," Potter adds. ■

Retention in Patient Access: The Struggle Is Real

Many patient access employees at Tampa, FL-based Moffitt Cancer Center are college students. Others are recent graduates. Neither group is inclined to make a career of patient access.

"They have gone to school for a set path for their future. The patient access role is not that type of position due to it being entry level," says **Marion Knott**, manager of clinic access. "It is difficult to retain patient access representatives, regardless of my efforts."

Recently, Knott met with the hospital's HR department to try to change this. Together, they updated patient access job requirements to include customer service. "We can train people on the medical aspects of the patient access role. But the role is mostly service-oriented," Knott explains.

Often, patient access applicants have no medical schedule experience. This makes them hesitant to apply for the role. On the other hand, most have lots of customer service experience. "They are smart and eager to learn the duties and make great employees," Knott says.

By changing the long-standing-but-outdated job requirements, it allows service-oriented applicants to join the department. "We are also recognizing their years of customer service in the pay offer," Knott adds.

Patient access has become highly service-oriented, but the previous job requirements did not reflect this. "By taking into account their past customer service when figuring a starting pay, it helps retain those service-trained individuals a little longer," Knott reports.

Of course, slightly higher compensation does not always make people choose patient access as a long-term career. However, it does cause some good registrars to put off leaving, at least for a little while. "It allows people to stay with me a bit longer before seeking other departments," Knott notes. Previously, patient access employees frequently left for other hospital departments due to even slightly higher compensation. "When other departments' pay ranges are higher than mine, it's hard to compete," Knott laments.

It is simply not possible for patient access leaders to double everyone's pay. Many times, even compensation that reflects the complexity of the job is not feasible. That does not stop smart leaders from providing other perks. "I have monthly lunches with up to a dozen people to provide more face time with me on a different level," Knott says.

Both leaders and employees learn about each other. This informal camaraderie extends into their work relationships. "When I visit their clinic, it helps them identify with me as a person and not just as their manager," Knott says. It also allows registrars from different clinics to get to know each other,

establish a contact, and put a face with a name. These meetings are held at a central location during lunch time so registrars do not have to travel or use their personal time to attend. Everyone brings a lunch, but Knott provides the dessert of choice: cupcakes. The topic of discussion varies. "We can talk about whatever they want. I allow them to set the tone," Knott says.

Sometimes, participants bring up work-related questions or topics. "But for the most part, it is more social," Knott says. "We all talk as a group and enjoy each other's company."

The department also created an Employee of the Quarter award. One person is nominated from each patient access area who really represents what it means to be a team player. This registrar receives an award to display on their desk, a certificate, and some candy. "It's a little something to demonstrate our gratitude," Knott adds.

The department does not forget Patient Access Week, established in 1982 by the National Association of Healthcare Access Management (in 2019, held from March 31-April 6). "We plan a great week full of fun and treats," Knott says. Each day, employees are celebrated in a different way. Breakfast is served one day, lunch the next, and small tokens are offered on the remaining days. "Staff like that — we take the time to do something each day of the week for them," Knott adds.

At Thomas Jefferson University Hospital in Philadelphia, patient access staff are treated to box lunches, given tote bags and mugs, and served ice cream and pretzels. These gestures do not require a huge outlay of time or financial investment. Still, it sends an important message.

June Parks, patient access supervisor of outpatient registration, says, "My staff seems to appreciate the fact that we recognize their hard work and commitment, both to the department and to our patients." ■

'I Can't Afford That' Payment Plans Are New Option

Back in the days when patients did not owe much more than a $20 copay, offering a payment plan would seem more an attempt at humor than a necessary solution. But with $5,000 deductibles the new norm, it is a different story.

"High-deductible plans, coupled with an increasing uninsured population, make payment plans essential," says **Yolanda Miller**, CHAM, director of patient access, preregistration services, and financial counseling at Floyd Medical Center in Rome, GA.

With soaring out-of-pocket costs, as many good options as possible are needed. "One size does not fit all," Miller says. "Having a variety of methods is good practice."

The first step is to nail down the dollar amount the patient will owe. "Our team has an estimation tool to determine amounts not covered by insurance," Miller notes.

The tool validates eligibility and patient benefits. It also factors in contractual rates negotiated with payers. Registrars then have in their hands the dollar amount that will not be covered by insurance. "The rep can then print an estimate letter to use for having the financial liability conversation with the patient," Miller says.

Payment plans are offered preservice as a part of the preregistration workflow if the patient will have a balance and cannot pay the entire amount. Two options are presented:

- If the patient can pay the balance in four or fewer payments, registrars offer an in-house, four-month payment plan at zero interest;
- If the patient requires more than four months to pay the balance, registrars help the patient apply for a zero-interest loan through an external vendor.

Some patients state that they cannot pay any amount. If so, registrars offer a financial assistance application. "Based on income, household size, and assets, the patient can receive discounts up to 100% write-off," Miller explains.

In the ED, the same process is used, but with different timing. The medical screening examination must be completed to comply with the Emergency Medical Treatment and Labor Act (EMTALA). Only then can registrars request payment.

"The same payment plan options are offered to the patient," Miller adds.

Registrars also offer payment plans in ancillary areas at the time of registration for nonscheduled services. "Patient financial services also offer the payment plans as a part of billing and follow-up process," Miller says.

Previously, staff struggled with how to collect high-dollar amounts. Often, they were reluctant to even bring up the topic of money because they were unsure how much the person would owe.

"Having the estimate letter as a tool has proven to be empowering for the staff," Miller says. "Having that document to review when asking for payment gives the staff confidence." Point-of-service collections started in

2016. Since then, ED collections more than doubled.

"We are seeing more patients of all types taking advantage of the zero percent finance option," Miller reports. One potential pitfall with payment plans is the length of time it takes to complete them.

"It is important to be consistent with the plans offered to avoid the long-term minimal payment plans that contribute to account aging," Miller says. When possible, registrars guide patients to a shorter-term option. "Also, financial assistance may be a viable option for the patient," Miller adds. "This should not be overlooked when discussing payment plans." ■

Avoid Issues With ABNs: Education Is the Answer

A patient is waiting for a clinical service, probably already with some degree of anxiety. At this point, few things are less welcome than the dreaded Advance Beneficiary Notice (ABN). The form asks patients to accept financial responsibility for the entire cost of the service if Medicare denies payment.

When the registrar asks the patient to sign it, acknowledging they may be paying for the service out of pocket, a blank look (or worse) typically follows. "Patients don't just show up at a hospital asking for services that aren't medically necessary. Their physicians send them," says **Kevin Willis**, director of Medicare services at Claim Services, an Aurora, IL-based claims adjusting company.

Upon learning that the scheduled service might not be covered, the patient typically will ask many questions. Some refuse to sign the forms, while others feel the need to call their health plan immediately.

"We have physicians ordering things that aren't covered, but we expect patients and/or the facilities to know when that's not right," Willis notes.

If Medicare denies the claim, the hospital is left with two bad choices. Neither is patient-friendly, and both are problematic for the revenue cycle. "Either the facility must tell the patient that their physician is wrong — never good — or the facility has to eat a bill for a service they didn't order, which is completely unfair," Willis explains.

At Lewes, DE-based Beebe Healthcare, patient access has confronted the troublesome ABNs directly.

"We have done a lot of work with our ambulatory provider offices to ensure they understand the process and reason behind ABNs," says **Maurice Winkfield**, director of patient access.

In turn, the offices educate patients. This is especially important at Beebe Healthcare due to the hospital's large Medicare population. "You want to make sure patients fully understand the ABN form if they are being asked to sign it and make decisions that may affect their wallet," Winkfield offers.

At Slidell, LA-based Ochsner Health, a major change was made in how ABNs are handled. "We really have removed ourselves from this process," says **Tanya Powell**, CHAM, patient access director of the health system's Northshore and Hancock regions.

Now, ABNs are completed by the clinical teams at the time the service is ordered. Previously, patient access handled the ABNs as part of the registration process. At the time the order is placed, a pop-up box appears in the registration system.

"It prompts us to review the diagnoses or activate the waiver form for the patient signature," Powell says.

When the appointment is scheduled, a prompt is shown stating that the CPT is not covered. Most helpfully, it also shows the associated diagnosis. Patient access then goes straight to the source: the Centers for Medicare & Medicaid Services website. "We then understand why the diagnosis does not work," Powell adds.

Lastly, patient access looks up the local coverage determination. This piece of information allows them to pay the claim to the benefit of both the patient and the hospital. "We can see what the documentation requires in order for the diagnosis to qualify," Powell explains. ■

Compassion, Empathy Keys to Complaint-Free, High-Dollar Conversations

What is the most difficult collection conversation? "Whenever the patient has not been made aware of what they will owe," says **Elkin Pinamonti**, MHA, assistant director of onsite access for Novant Health's greater Winston-Salem, NC, and northern Virginia markets.

Patient access preregisters as many people as possible. This gives registrars the chance to fully discuss the patient's financial responsibility. "But we are seeing more and more add-on procedures. This makes it difficult to alert the patients prior to the date of service," Pinamonti reports.

Typically, patients face the highest out-of-pocket costs with outpatient surgery. "That makes that service the most difficult when it is not priced and communicated to the patient prior," Pinamonti says. Regardless of the amount, registrars have found it is possible to engage in financial conversations without too many complaints. It all starts with good manners. "We put compassion and empathy at the center of every financial conversation we have," Pinamonti says.

Even when collecting thousands of dollars is necessary, it is still possible to convey that the patient's well-being is the registrar's top priority. "We frame the conversation with an educational basis," Pinamonti explains. Patients ask many questions about what they owe and why. "When we deliver information on their options, we become an advocate," Pinamonti says. "This reduces anxiety." For patient access, a great deal of knowledge and training is necessary to engage patients in high-dollar discussions. "Team members also need a comfort level to ask for payment," Pinamonti adds. Financial conversations are part of new hires' training. "We include a focus on customer service, paired with the individual components of insurance and how it works," Pinamonti says. Once the initial training is completed, onsite preceptors conduct simulations with team members. This helps new team members eventually engage in these discussions in the real world. "We continually re-educate so our team fully understands how to navigate these conversations," Pinamonti notes.

It does not matter how much financial counseling training someone's gotten at Salt Lake City-based Huntsman Cancer Hospital. He or she can expect to keep getting more training for as long as he or she works at the hospital.

"Things are constantly evolving," says **Junko I. Fowles**, CHAM, supervisor of patient access and financial counseling. Authorization requirements are added, new insurance plans enter the marketplace, and required documentation changes. "It's impossible to provide exceptional care to our patients without being informed of the latest information," Fowles says.

Patient access staff receive training in four areas continually: system upgrades, payer updates, customer service (via online modules), and financial counseling (conducted in person). In oncology, registrars also receive specialized training in pharmacy assistance programs to help patients cover out-of-pocket costs.

Of course, all this training is not worth much if patients are unhappy. Leaders tell registrars exactly where they stand in this regard.

"We share patient comments, both negative and positive, with the team," Fowles says. "We know exactly what our current challenges are." ■

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