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INSIDE

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For Patient Access, COVID-19 Means 'New Normal Every Day'

Countless news stories are reporting on what clinicians are facing in overwhelmed emergency departments (ED) and intensive care units during the COVID-19 pandemic. However, few people realize what is going on behind the scenes in patient access.

"We are adjusting to a new normal every day," says **Craig Pergrem**, senior director of revenue cycle, onsite access, and financial counseling at Winston-Salem, NC-based Novant Health.

At Memorial Hermann Health System in Houston, fluctuating patient volumes have driven many changes. "This has impacted staffing needs and job responsibilities," says **Shannan Dillard**, director of patient business services.

Instead of working at their usual cubicles or registration areas, patient access employees now are stationed at triage tents outside facilities. "We are working elbow to elbow with our ED clinical teams," Pergrem reports.

The health system's emergency operation plan for patient access as a whole is in effect. The plan is fine-tuned by each facility's patient access department, based on its unique needs and scope of services. A large hospital may need five extra ED registrars, for instance, while a smaller hospital needs two.

Patient access has four different levels of staffing planned, depending on the severity of the outbreak. "This includes our own staffing being reduced due to illness," Pergrem explains.

The department created "pandemic" codes to allow some employees outside of patient access to register patients. These employees (who normally handle preregistration, preservice collections, and scheduling) receive some online training first. They can use critical access sign-ons, allowing them temporary access to register patients. "This allows them to come to a site in need of assistance and immediately have an impact in registration of our patients," Pergrem says. Once the pandemic abates, the sign-ons can be canceled when appropriate.

Nonurgent surgeries and procedures were rescheduled. Patient access employees who normally would work those accounts have been moved elsewhere. "The big drop-off in volumes frees up additional staff to assist where needed," Pergrem observes.

Face-to-face encounters always have been an integral part of the job of patient access. The following are three examples of how in-person processes are handled remotely at Novant Health:

• **Consents and financial counseling for admitted patients are handled by phone.** Typically, these are conducted

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at bedside. "We are now looking at whether we need to send team members to rooms for signatures," Pergrem says. At press time, the department still was evaluating if state agencies will allow some consents to be handled by phone during the pandemic.

• **Registrars are explaining required signatures for the Medicare Outpatient Observation Notice (MOON) and Important Message from Medicare; nurses are obtaining signatures.** "With agencies still requiring signatures, we are telephonically explaining these to the patient or family," Pergrem reports.

Nurses obtain the actual signatures from patients at some point during the day. This helps save personal protective equipment, since only one person is going into the patient's room. Later, registrars notate in the system that the patient's signature was obtained.

• **Preregistration and scheduling are no longer handled on site.** Hundreds of employees were sent home to work remotely. "Our centralized billing office, which houses them, has gone from 300 to 14 team members working on site," Pergrem says.

The onsite employees perform any task that cannot be handled in a home setting, such as sorting through incoming mail and printing materials that require mailing. "This allows business to continue to flow normally with a tweak in timing," Pergrem adds. Keeping up morale during the pandemic has become a top priority for patient access. "Our biggest challenges are meeting with team members to ease their own fears," Pergrem says. Mainly, patient access leaders are doing this by cautioning employees to obtain information only from reliable sources (e.g., the Centers for Disease Control and Prevention website and the health system's own intranet site).

Memorial Hermann's patient access department is no stranger to disasters; the area regularly faces floods and hurricanes. But with COVID-19, "the most difficult challenge we have seen is less about tasks and the ability to staff our areas. It is more about keeping the team morale positive," Dillard says. "Not only are we balancing multiple changes in volume and needs at the facilities, we are also balancing how we handle our personal lives and needs of our families."

Leaders are in constant communication with staff to alleviate concerns. New processes for ED registrations of respiratory patients and rescheduling of elective cases were shared immediately. "Every possible change that can be predicted is reviewed throughout the day," Dillard explains.

There are other ways processes have changed in patient access departments:

• **Staff re-allocation.** At Los Angeles-based Ronald Reagan UCLA Medical Center, patient access is working hard to maintain enough staff

EDITOR'S NOTE

This is a special issue of *Hospital Access Management* on how the COVID-19 pandemic has changed patient access. Almost overnight, registration, scheduling, financial counseling, and collections all were upended. We report on how staff are handling different roles, working in different locations, and using different tools to complete their jobs. A future issue will cover long-term changes for the revenue cycle, and how hospitals are staying financially viable.

in registration areas onsite. "This is a top challenge," says **Drew D. Totten**, principal administrative analyst for patient access services.

At the same time, the department is busy configuring equipment and processes to allow other patient access staff to work from home.

"We're working to ensure there's adequate work for the staff to do remotely," Totten adds.

• Postponing planned "go-lives." The patient access department at Mt. Graham Regional Medical Center in Safford, AZ, was in the process of a computer conversion, with a go-live date of April 1. Travel restrictions prevented the vendor from working on site. "The decision was made to postpone it," says **Julie Johnson**, CHAM, FHAM, director of health information management and patient access.

• Putting contingency plans in place to ensure adequate staffing. Since someone takes the temperature of every patient access employee before he or she enters the hospital, there is a chance the department suddenly will find themselves short-staffed.

If anyone is sent home, that means someone has to cover for that person without notice. At Mt. Graham, a designated person is assigned for this. "We have one on-call employee to cover any shift," Johnson notes.

• Directing patients to handle many tasks remotely. "We are emailing, faxing, mailing, and signing patients up over the phone for our patient portal to keep foot traffic to a minimum," Johnson reports.

• Even lunch breaks have changed. Instead of socializing in the cafeteria, staff call in to-go orders to pick up. "We do this on a staggered schedule to avoid congregating in the department," Johnson adds. ■

Registrars Redeployed to Cover Overwhelmed EDs

At Connecticut Children's Medical Center, staff who handle scheduling, authorization, and financial counseling are working at home. However, the same is not true of emergency department (ED) registrars.

"Right now, we are struggling with decreased volumes of outpatient areas and redeployment of staff," says Interim Director of Patient Access **Jessica Budri**, RN, MSN, APRN.

Staff who normally would be obtaining authorizations and financial clearance for upcoming procedures are instead busy notifying people that procedures are not happening as scheduled. After that, they have little to do, since volume at the freestanding children's facility has not increased like many adult systems. "We redeployed staff who are cross-trained to the ED," Budri says.

At University of Utah Hospital (part of University of Utah Health), a revamped ED registration process is in effect. As at many hospitals, patients presenting to the ED are triaged in an outdoor tent. "We have a couple of ED registration staff in full PPE [personal protective equipment] to mini-reg these patients," says **Junko I. Fowles**, CRCP-I, CHAM, supervisor of patient access and financial counseling at Salt Lake City-based Huntsman Cancer Institute (also part of University of Utah Health).

Registrars collect just enough information to identify the patient (name, date of birth, and Social Security number) to create a medical record. ED registrars complete the registrations by phone and verify demographic information, insurance, emergency contact, preferred pharmacy, language, and spiritual preference.

Patients with non-COVID-19-related illness or injuries are brought inside, and the normal registration process is followed, but not always by a registrar who normally works in the ED. Admitting registrars were cross-trained to cover the ED some time ago, and it is coming in handy now. "ED staffing turnover has been an ongoing issue. We always had back-up staff to help out if the ED was short-staffed," Fowles says. "That has helped us tremendously."

Registrars are encouraged to use the employee wellness center and employee assistance program as needed. "We are witnessing increased anxiety and stress level among our employees," Fowles observes.

Most registrars just want their concerns to be heard by colleagues. "Sharing their experience with peers is a common coping strategy, and seems to be working," Fowles reports.

ED registrars are doing their best under unusual circumstances. Meanwhile, financial advocates at Huntsman Cancer Institute are telecommuting to reduce COVID-19 spread among the immunocompromised patient population. Admitting staff who complete inpatient registration at the University of Utah Hospital are doing so remotely for accounts with a "precautions" flag (meaning a pending or positive COVID-19 test).

All of this is going to affect revenue. For now, that is taking a back seat to safety.

"We are aware of the negative impact the new workflow may have,"

Fowles notes. Inevitably, some accounts are going to be missed because of the inability to complete in-person interviews and all of the necessary paperwork. "We are doing our best to minimize potential financial loss down the road," Fowles says. "Our top priority now is patient safety as well as employee safety." ■

Revenue Cycle at Forefront of Organizational Changes

At hospitals across the United States, administrators had to quickly create effective processes to separate COVID-19 patients from other patients. At Emory Healthcare in Atlanta, revenue cycle leaders were closely involved in this.

"I've been working with a legacy system I support to modify and/or reconfigure a number of units to accommodate patients with various acuity levels," reports **Peter Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations. These two issues became important:

• How to change the default accommodation code of a bed or unit from private to intensive care unit to address the anticipated acuity of patients who will cohort there;

• How to ensure accounts eventually will be billed correctly to reflect patient treatment. "We have lots of beds and units at our hospitals, and lots of leaders with new ideas of how to cope," Kraus explains.

Revenue cycle leaders also are involved in the patient population reporting side. Kraus says there are two main questions: How can staff accurately identify the COVID-19 population in general? What about various subpopulations (e.g., patients taken from cruise ships and sent to a local Air Force base for isolation, and were admitted to the hospital)?

The department added COVID-19-related CPT/HCPCS codes. At least some payers, possibly including Medicaid, will require these. "But it's too early to know how the billing process will evolve when we get through the worst of the pandemic," Kraus notes.

While billing and reimbursement are critical to the financial viability of hospitals, Kraus says current efforts are focused on identification, containment, and treatment of patients with the virus, as well as protection for care providers. "If front-end identification and accurate documentation facilitate the billing process, so much the better," Kraus offers. "But at this stage, it is secondary to many more important matters."

At Spectrum Health in Grand Rapids, MI, patient access adapted quickly to the COVID-19 pandemic. "So far, most of that change has been related to our contact center," says **Maria H. Kamenos**, CHAM, CHFP, vice president of patient access services.

In the early days of the crisis, patient access was asked to set up an internal information line. Clinicians and operational leaders use it to connect with nurses trained to answer questions about COVID-19. "This line was set up to support our infection prevention team, who were already fully engaged in responding to the situation," Kamenos explains.

Patient access staffed it using the primary care nurse triage team from its contact center. "As we began to cancel elective services and ambulatory clinics, we simultaneously created COVID-19 virtual screening capabilities," Kamenos notes.

Patient access quickly created a 24/7 scheduling line for this service. "We redeployed team members from all over the organization to staff this line," Kamenos reports.

This included more than 400 physicians who perform the actual screenings. During the first three weeks, staff took more than 24,000 calls. "We have scheduled over 17,000 telephone screenings for patients across Michigan and 27 other states," Kamenos adds.

Patient access also is responsible for scheduling and check-in of patients accessing drive-through COVID-19 testing tents. "We also have a dedicated phone line for employees who have symptoms that need further investigation before they can safely be cleared to work," Kamenos says.

Hospital-based registration and financial counseling teams are acting as screeners at various checkpoints to ensure no symptomatic people enter the hospital. "As we initiate plans for overflow beds — and, potentially, new sites for stable patients — we will provide registration support in those locations as well," Kamenos says. ■

COMING IN FUTURE MONTHS

- Speed payer response times for payment of claims
- What COVID-19 means for upfront collections
- Responses to unproductive remote registrars
- Recoup lost revenue from rescheduled surgeries

Flexible Shifts Smooth Sudden Transition to Remote Work

Hospital registration has suddenly moved from face-to-face encounters that happen right when the patient presents, to a work queue-based task handled remotely.

"We have created a process that we refer to internally as 'slim reg.' It has reduced our patient-facing registration time to one-fourth of the regular process," says **Daniel J. Plavsic**, MBA, CRCRC, executive director of time of service for system patient access at Indiana University (IU) Health in Indianapolis.

Most, although not all, of IU Health's registrars now work at home. This has allowed the department to continue operations despite school closings and self-quarantines of asymptomatic employees exposed to the virus. On site, registrars gather just enough information from patients to identify them. "This immediately lands on a worklist for our newly remote team members to complete the registration," Plavsic says.

Off site, staff use previous registration information in the electronic medical record and insurance coverage given by the patient to confirm the insurance is active. Sometimes, additional data or signed documents are needed. If so, the registrar calls the patient in their room to learn the information and/or obtain verbal consent. "Each day, we find additional ways to optimize our process," Plavsic reports.

Overall, the "slim reg" process has been successful. The department is seeing solid performance metrics with it. For staff, "slim reg" opened up some much-needed unscheduled personal time — and could do so again in the future. "We believe this model can be sustained and optimized, long after the COVID-19 crisis," Plavsic says.

Allowing some registrars to work at home had long been considered at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE. It sounded appealing in some ways, but problematic in others, and the switch never actually happened. "My biggest concern was the associate engagement. I was fearful of the team disengaging and losing that team atmosphere," says **Stacy Hutchison-Neale**, CRCR, CHAA, manager of the physician referral/authorization department.

Most staff were not too keen on working at home, either. "They wanted the human interaction," Hutchison-Neale says.

When COVID-19 hit, no one had a choice in the matter. Almost overnight, everyone was working remotely. "All of the team is working from home, including management," Hutchison-Neale reports.

For the first time, staff were performing their jobs without their familiar cubicles, computer screens, and colleagues. It was not an easy transition, but one thing helped tremendously: flexibility. "We offered flex shift options to ensure associates' needs are met," Hutchison-Neale says.

For some employees, tending to kids who are at home from school was their biggest concern. Others wanted to shore up their finances and work longer hours. Staff were asked to choose to work shifts of four, eight, or 10 hours. After a short adjustment period, most registrars have been very productive. "I find that I am very focused during the time working from home and pushing out the same number, if not more, claims than I would in the office," says authorization specialist **Jessica Ridley**.

The first issue was the need to respond to dozens of voicemail messages left by families wanting to know how the situation would affect their scheduled services. All employees' regular responsibilities also are in full gear. "We are business as usual," Hutchison-Neale says. "We check in multiple times a day to ensure that we are all on the same page."

To keep things running smoothly, the department is running registration productivity reports and monitoring for large gaps in time. "All breaks are scheduled to ensure that we have full coverage throughout the day," Hutchison-Neale explains.

At home, staff are obtaining authorizations and referrals just as they normally would. The timing is what has changed. "The teams are now advised to work as far out as they can," Hutchison-Neale says. "We have told them to get out as far as possible."

Staff always tried to work ahead as far in advance of scheduled services as they could. The volume of work always held them back.

"Usually, the furthest they could manage was about 30 days out for surgeries, and 15 to 18 days for office visits," Hutchison-Neale notes.

That changed because of all the rescheduled and canceled procedures. If a surgery is rescheduled six months or even one year out, and the insurance company allows it to be authorized, staff do so. Working ahead in this way is going to help the department going forward. "This is the silver lining in a bad situation," Hutchison-Neale observes.

At one point, all the canceled surgeries and procedures are going to happen. Securing all the authorizations well in advance is going to be helpful. Those claims will be paid without issues, freeing up staff to secure authorizations for emergent surgeries and procedures. When the crisis is finally over, explains Hutchison-Neale, "we can be very focused on the last-minute add-on requests." ■

Registration Areas with Low Volumes: 'Great Deal of Down Time'

Even with schools closed and daily schedules turned upside down, patient access staff at Winston-Salem, NC-based Wake Forest University Baptist Medical Center are not calling out.

"They have made the necessary adjustments, and are making it to work every day," says **Monica Brown**, MPH, associate director of operations for the Downtown Health Plaza and Winston East Pediatrics.

The problem is some registrars suddenly have little to do. All the work they normally handle at a hectic pace (e.g., registering people for outpatient procedures) is on hold. Registrars are going to be working fewer hours or relocated to other areas. "With a much lower volume of patients, we are having to develop a different staffing model," Brown acknowledges.

At North Mississippi Health Services, "patient access has a great deal of down time," says **Carol Plato**, vice president of revenue cycle.

Staff are no longer registering patients for inpatient or outpatient elective procedures; those are all canceled. They also are not collecting copays from emergent patients.

"We made a decision to hold off on point-of-service collections until the situation has passed," Plato reports. However, staff continue securing much-needed revenue, but in a different way. Most are now working in the central business office, calling payers to ask for the status of unpaid claims.

"They did not need much training since they are used to speaking with insurance companies," Plato observes.

Registrars also are busy performing a root cause analysis on claims denials. In the process of doing this, says Plato, "they are learning how much time it takes to correct errors." Payment delays for previously submitted claims have become even more problematic. "With volumes so low and an increase in supply chain costs due to COVID-19, payers should pay claims faster and without denials," Plato offers.

Some health plans have promised to forgive copays on claims that end up with a COVID-19 diagnosis. So far, the health system has not seen many of those.

"State and federal legislatures should mandate that payers pay hospitals all outstanding claims immediately," Plato notes. "Payers are actually saving money, while hospitals are struggling."

The department is looking at the difficult prospect of cutting hours for patient access staff, possibly to 36 or 32 hours per week.

"That has not happened yet. But if we don't get back to normal visit levels soon, it will be a reality," Plato says. ■

Revamped ED Registration for COVID-19: 'All Hands on Deck'

When Banner - University Medical Center Tucson implemented a triage and registration process for emergency department (ED) patients with symptoms consistent with COVID-19, revenue cycle leaders were right in the middle of it.

"Our revenue cycle team was tasked with tracking these patients as they presented, and identifying how we would ensure appropriate billing for each visit," says Patient Access Director **Ian Jensen**, MHA. The new process removes COVID-19 patients from the general ED. Patients are screened, assessed, registered, treated, and discharged in an outdoor area. The entire process takes between 20 to 30 minutes. First, patients drive into a multistall screening area, where vital signs are taken and an acuity level is assigned. High-acuity patients are brought to a section of the ED that is physically separate from the general ED. There, registrars use eligibility checking tools, signature pads, and collection devices. "With our mobile workstations, it's as if the rep was sitting at a registration desk," Jensen says.

Lower-acuity patients drive up to a registration tent. "They are greeted by a rep who collects all of the required information to complete registration," Jensen explains. Consents and signatures are handled verbally to reduce risks for both patients and staff. "Once all access functions are completed, labels are printed," Jensen says.

The patient drives to the final tent for testing (nasal or throat culture). Lastly, nurses give discharge instructions. Throughout all of this, "our revenue cycle team maintains accuracy of insurance and demographics for clean claims," Jensen says. These changes were made:

• A new payer code was created in the registration system to be added to the patient's medical record number.

"This allows us to quickly track volumes of patients coming in and their associated acuity," Jensen reports.

• Registrars use eligibility tools on mobile work stations to validate patients' insurance. "This is done in real time while the patient is in front of the registration rep," Jensen explains. The same tool flags errors so registrars can fix them right away during the registration process.

• The department moved its equipment (label printers, scanners, collection machines, and computers) to the outside screening area. "This allows a faster turnaround time," Jensen says. Registration takes two to four minutes on average, and five minutes during peak volumes.

Overall, the triage and registration process is not only safer for everyone involved, but also efficient. "We provide quick, yet thorough, registrations," Jensen adds.

Normally, ED registrars see from 200 to 230 patients a day. "The new process allows us to accommodate over 450 patients," Jensen says.

Four or five additional registrars are needed to accommodate the higher volumes. "Staffing challenges will always be the No. 1 logistical problem we face in incidents like this," Jensen notes.

Registrars are brought in from other areas: outpatient check-in, inpatient registration, and outpatient infusion. "All will be monitored for accuracy and quality metrics, the same as with other ER registrars," Jensen says.

Outpatient surgery volume decreased by 60% at the facility.

"We repurposed our staffing resources that are normally dedicated to registering these outpatient modalities to focusing on the screening process," Jensen reports.

Those registrars already were cross-trained to work in all areas, including the ED. "Staff are able to fix registration errors in real time while they register patients," Jensen says.

Any incorrect insurance information, policy numbers, or subscribers will cause denied claims. "We are monitoring these registrations and correcting all errors prior to the day's end," Jensen says.

This is handled the same way as before the pandemic. A quality tool allows viewing of all the accounts any specific rep worked on for any given time.

"From there, we can monitor all alerts that would prevent a clean claim," Jensen says.

The hospital's quality assurance team shifted its focus to COVID-19-related accounts. "During this time, we are all hands on deck," Jensen says.

The goal is to maintain registration quality in the high 90th percentile.

"We want to make sure that the facility's A/R days remain consistently low, and that our unbilled days are maintained lower than four," Jensen offers.

For inpatients, collections are handled by phone instead of face-to-face interactions. When patients are checked in, registrars verify insurance eligibility. "We use tools that offer coverage discovery to ensure all appropriate payers are identified. From there, we are able to collect over the phone, much like a pre-reg account," Jensen says.

This same process is used in the ED's respiratory waiting room. Registrars use phone numbers provided at check-in. "We then complete the registration and collection over the phone," Jensen adds.

School teachers nationwide had to learn on the fly how to teach remotely. Revenue cycle educators at Banner Health did the same.

"We were challenged to modify training in order to communicate changes affecting acute and ambulatory settings," says **Amber Hermosillo**, revenue cycle educator and quality director. Two types of training were needed urgently:

• For existing patient access staff. Trainers used Adobe Connect to report on the new processes used for COVID-19. The switch did not come easily. "Our patient access team is used to face-to-face, facilitator-led trainings," Hermosillo says.

• For staff outside of patient access who now are registering patients. A mix of corporate staff from revenue cycle service lines, central billing offices, analytical teams, and various other positions are helping. An educator covers the basics of registration via Skype. "There are times we have minor technical issues," Hermosillo notes. "Overall, the staff, trainers, and leaders embrace the virtual platforms, with reasonable engagement." ■

Financial Counseling During COVID-19: Mix of Old School, New Tech

Normally, financial counseling at UnityPoint Health's hospitals is handled face to face and by appointment.

"We are now having to do it by phone, FaceTime, or mail. We have to shift gears and meet the needs of the patients," says **Linaka Kain**, DE, regional manager of patient financial coordinators and the marketplace exchange.

Financial coordinators continue working onsite. "We will probably be one of the last groups to work from home, besides registration," Kain predicts.

One obstacle to at-home work is that some financial counselors lack laptops or wi-fi.

"People don't think about that until something like this happens. Then, everybody scrambles," Kain observes.

The department is now thinking ahead. "If something like this happens down the road, we could have a team of multiple financial counselors working from home, with one person working in-hospital," Kain offers.

For now, counselors are filling out paper applications, mailing these (with postage-paid envelopes) to patients to sign, then entering the information into the portal.

"It's almost going backward," Kain notes. "Back in the day, when everything was done by mail — now we're back to doing that."

Some patients want to complete the applications over the phone but want personalized help. They ask financial coordinators to FaceTime them. "People are out there during this crisis and need help," Kain says. "If it means FaceTiming with patients, sometimes that's what you have to do."

The department has seen an increase of about 20% in uninsured since the federal tax penalty for not being enrolled in health insurance was removed in 2019.

"A lot more people have not gotten coverage in the last year. Consumers and patients think it's thousands of dollars a month to get a plan because of what they hear on the news," Kain says.

Financial counselors let them know there are less expensive options.

"The [Affordable Care Act] marketplace has a lot of no-premium plans," Kain says. "There are plans with $5 premiums that were even better than many large employer plans."

The self-pay population has increased since the dawn of COVID-19, too.

"People are in a panic, and everybody wants to be seen and tested. We are seeing a bigger influx of self-pay," Kain reports. About 25% of this group is converted from self-pay to Medicaid coverage.

The underinsured patient population also is growing. The department is seeing many more people with high deductibles and large out-of-pocket costs. Many of these people have Medicare, but do not qualify for Medicaid as secondary insurance, which carries the same benefits as traditional Medicaid.

"That group is significantly higher than I've ever seen," Kain adds. ■

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