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## INSIDE



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# Telehealth Offers Much-Needed Revenue in Near-Term, but Future Reimbursement Is Unclear

At Augusta Health in Fishersville, VA, new registration processes for telehealth happened almost overnight. Now, facilities are making adjustments.

"We are learning to crawl before we walk," says **Andy Long**, administrative director of cardiovascular services.

Previously, Augusta Health offered only limited telehealth services for specialty care. About 90% of care now happens virtually, a change that overhauled patient access processes. "It's a shift in dynamics," Long notes.

Once telehealth visits were underway, things did not always go as planned.

"Due to nationwide demand, there were bandwidth and technological instability issues," Long reports.

Patient access switched to obtaining registration information over the phone instead of in person. Helping all specialties bring their telehealth online was another challenge.

"We have successfully worked through and overcome any glitches," Long says.

Both registrars and patients have gotten used to telehealth. Going forward, says Long, "virtual medicine will be more widely used on a standardized HIPAA [Health Insurance Portability and Accountability Act]-compliant platform." The department plans to offer web-based scheduling eventually.

Some things have not changed. Registrars still collect the same demographic data from patients. They verify insurance at each visit to ensure the hospital receives payment. "The data collection that occurs during the registration process is pretty similar in a virtual environment," says **Katie Adams**, director of patient financial services.

Registrars no longer scan physical insurance cards. Instead, they confirm coverage electronically. "The expansion of telehealth services has been a major benefit to our organization, to supplement the decrease in face-to-face visits," Adams says.

Most contracted payers are covering telehealth services. "But if and when this changes, there will be a need to verify specific benefit coverage prior to the visit," Adams adds.

For now, hospitals receive the same payment regardless of whether a visit is virtual or in-person. "We are settling into the new virtual norm, and our payers are neutralizing reimbursement for virtual visits," Adams explains.

Revenue cycle leaders are keeping a close eye on any policy changes that could

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affect reimbursement. "Unexpected claims denials are always a concern," Adams says. The Centers for Medicare & Medicaid Services (CMS) issued clear expectations on how telehealth claims need to be handled.[1] Health plans are a different story. "Some large commercial carriers are not following CMS protocols, and are hesitant to answer direct questions on their expectations," Adams reports.

Departments fear the possibility of future claims denials since health plans cannot clarify their own requirements. "Many times, it forces us to be reactive instead of proactive," Adams says.

Whether telehealth reimbursement continues is anyone's guess. "We are waiting in anticipation to see if CMS and our contracted payers will continue to support telehealth services beyond the initial response to the pandemic," Adams says.

Health plans could keep paying for telehealth visits. On the other hand, the health plans could revert to business as usual, and decide to pay for in-person visits only. "If telehealth continues to be supported by our payer community, we will continue to offer it as an alternative care model," Adams says. Health plans have made no long-term promises. Some payers allowed telehealth coverage for 90 days, with no guarantee of payment after that time. "We are nearing that point," Adams notes. "We have been asking if they will provide extensions. We aren't getting clear direction."

When patients are offered a telehealth appointment, they want to know whether their health plan covers it. "That assurance is difficult to give when the insurance companies aren't providing it," Adams observes. "The individual who suffers most from this lack of clarity is the patient."

Because of the poor communication from health plans, patients worry about winding up with the bill. "We assure them we will continue to stand with them," Adams says. "We will do everything we can to ensure they receive the services they need." So far, at least, there are no definitive answers. "We are thirsting for information from our payer community," Adams adds. "In most cases, it simply isn't there." ■

## REFERENCE

1. CMS.gov. Medicare telemedicine health care provider fact sheet. March 17, 2020. https://go.cms.gov/2AvDwTk

# Telehealth Reimbursement Continues to Evolve

The sudden growth of telehealth "will upend financial dynamics across the healthcare continuum," predicts **Anton Arbatov**, MHA, FACHE.

Ultimately, patient visits probably will generate less revenue for hospitals. That is because telehealth generally is reimbursed at a lower rate than in-person care, and with more restrictions on what is covered.

"Telehealth will likely reduce the frequency of emergency department visits and reduce revenue from procedural billing," says Arbatov, vice president of revenue cycle management and compliance at SOC Telemed, a Reston, VA-based provider of acute care telemedicine services.

For patients, coverage limitations for telehealth mean high out-of-pocket costs. "This will also impact provider revenue due to historically low patient payment collection rates," Arbatov says.

For the field of patient access, the telehealth boom carries some broader implications. "As more patients become

familiar with using telehealth, they are demonstrating a desire for additional digital interactions with providers," says **Bill Krause**, vice president of connected consumer health at Nashville, TN-based Change Healthcare.

After receiving virtual care for the first time, people are going to expect more of the same. They will be looking for self-serve scheduling, registration, check-in, and payment, according to Kraus. "Creating a more retail-style digital experience for consumers will help hospitals compete with nontraditional providers," he says. Those include urgent care centers and clinics located in retail stores. "Care is moving to the lowest-cost setting," Kraus adds. "Telehealth is just one more competitor in this arena."

There are two main questions for revenue cycle departments: Are health plans going to pay for virtual visits? If so, how much? "As telehealth expands its scope of services, reimbursement policy will continue to struggle to keep pace," Arbatov observes.

Patient access departments can maximize telehealth reimbursement in these ways:

**• Keep up with federal, state, and payer policies.** "For example, consent laws are state-specific," Arbatov notes.

In most states, the standard consent form obtained during registration is adequate for telehealth. In other states, telehealth-specific consent is required at the point of care. "Pay close attention to evolving policy," Arbatov cautions.

**• Ensure telehealth services meet billing compliance requirements.** For instance, in consultative services, providers at the originating site must document the order for a telehealth consultation. "At the distant site, providers must document the duration of the encounter, among other elements," Arbatov explains.

**• Work with health plans to understand eligible billing codes and required modifiers.** "Ensure that these codes are part of contracted fee schedules," Arbatov stresses. For the duration of the national emergency declaration, the Centers for Medicare & Medicaid Services (CMS) made more than 80 new CPT codes eligible for telehealth reimbursement.[1] "However, that does not mean that all payers followed suit," Arbatov says. For example, emergency department (ED) visits are now eligible telehealth codes for Medicare. Yet not all commercial health plans are paying for telehealth ED visits.

**• Obtain specifics from health plans on how long telehealth reimbursement will continue.** "Uncertainty, coupled with chaotic policy changes, creates risk," Arbatov says. To avoid lost revenue, patient access leadership must press health plans for specific time frames. Expecting frontline staff to keep track of it is not realistic. "It is up to the providers to ensure that appropriate eligibility-filtering workflows are in place to avoid denied claims," Arbatov says.

Many registrars never handled a single telehealth appointment before the pandemic. Other hospitals already had some experience with it. "The places that have done best with telemedicine are those who were doing it in some way in the past and could rapidly bring it up," says **Lorraine Possanza**, DPM, JD, MBE, program director of ECRI Institute Partnership for Health IT Patient Safety. Logistically, the switch to telehealth generally is simpler for everybody. When it comes to reimbursement, the situation is a bit more complex. "Everybody has a mistaken impression that it's so much easier, and that it is possible to rapidly get patients in and out. But there are many things that have to be done to complete the visit," Possanza says.

None of the waived requirements from the federal government, states, and commercial health plans are permanent or foolproof. All come with limitations. "Those kinds of things are going to be important moving forward, or people aren't going to get paid for care," Possanza says. For each payer, these specifics are needed: Who can provide the care? What type of care is covered? What type of technology is acceptable? Does there need to be a video component in the visit? Does a secure application need to be used, or is FaceTime OK?

Nailing down these details could determine if hospitals end up with much-needed revenue or mountains of bad debt. "This is something to be mindful of, moving forward," Possanza says. ■

## REFERENCE


1. CMS.gov. Covered telehealth services for PHE for COVID-19 pandemic, effective March 1, 2020. Updated April 30, 2020. https://go.cms.gov/2XmU8Wr

# Payers, Providers Speed Care by Agreeing on What Does Not Need Authorization

The prior authorization process is nothing short of infuriating to patients and medical staff, the authors of a study concluded.[1]

Even before starting their research, the investigators were well aware of this reality. "We knew the process was burdensome not just for the patient, but also for the clinician and office staff," says **Michael Evans**, RPh, one of the study's authors and vice president of enterprise pharmacy and chief pharmacy officer for Danville, PA-based Geisinger Health System.

Researchers conducted focus groups with 13 patients insured by an affiliated health plan. All had at least one medication claim denied in the previous year.

"Patients don't understand the process," Evans says. "They get frustrated because after being diagnosed with a disease, they need therapy. Sometimes, it takes weeks for prior authorization to go through."

Investigators also conducted focus groups with nine physicians and office staff. This group viewed authorizations as "a lot of extra work that adds no value," Evans reports.

A strong theme of frustration, anger, and anxiety emerged. Patients said they needed an advocate. Providers said they needed a list of medications requiring prior authorization. "We knew before this study that the process was antiquated and broken," Evans says. "We needed to do something about it."

Prior authorization first came about under a fee-for-service model. Geisinger Health System (and healthcare in general) is moving to a value-based model with revenue tied to efficiency.

"That means eliminating prior authorizations, which are not adding value and are actually adding cost," Evans explains. At Geisinger Health System, some important changes were made to keep prior authorizations from interfering with patient care, specifically for people insured by the Geisinger Health Plan. "We are practicing evidence-based medicine. We didn't want the prior auth process getting in the way of that," Evans says.

The amount of time spent on prior authorization varies significantly based on medication and payer. "Presenting providers with evidence-based clinical pathways standardizes drug selections. It eliminates the need for excessive processing time," says **Ann Marie Petrochko**, RPh, who is leading Geisinger's redesign of prior authorization processes. Petrochko is director of pharmacy operations at Geisinger's CareSite Specialty Rx.

> AN AGREEMENT WAS REACHED TO LIMIT THE NUMBER OF MEDICATIONS THAT NEEDED PRIOR AUTHORIZATION.

Some medications are approved 99% of the time. For these drugs, securing authorizations is a waste of time and money for both payers and providers, according to Evans. On the other hand, some drugs need prior authorization for patient safety. "The problem was that the application was too broad," Evans observes.

To help patients receive the treatment they needed faster, an agreement was reached to limit the number of medications that needed prior authorization. "This is the direction we all need to go in," Evans offers.

The health system is closely tracking patient outcomes. "We don't just do this and walk away. We have monitoring around it on a high level," Evans says. "But we don't get in the way of day-to-day patient care."

Prior authorizations typically result in cost savings for payers and higher costs for providers. "But when you remove the prior auth, and you are in value-based care, you remove the expense, and you increase access to the appropriate therapy," Evans says.

With this model, the payer's quality metrics also should improve. "If payers are aligning their formulary and contracts with best practices, they should be financially in a better position as well," Evans explains.

Pennsylvania's Medicaid program recently created its own Preferred Drug List. This means all managed care organizations have to follow this formulary for Medicaid patients. "This creates a criterion where we need prior auth, no matter what. That is not a direction we want to go in healthcare," Evans says.

If prior authorizations are eliminated with upfront agreements, it frees up patient access staff. Registrars can instead help patients understand their coverage and out-of-pocket costs. "That's a gap today, and it's growing faster than we are plugging it," Evans adds. ■

## REFERENCE


1. Jones LK, Ladd IG, Gregor C, et al. Understanding the medication prior-authorization process: A case study of patients and clinical staff from a large rural integrated health delivery system. *Am J Health Syst Pharm* 2019;76:453-459.

# Prompt Pay Discounts Can Reduce A/R Days, but Consistent Policies Are a Must

If a patient can pay the entire balance up front, and receives a nice discount for doing so, it is a win-win.

"Prompt payment discounts decrease A/R [accounts receivable] days and reduce costs incurred. It is, overall, a patient satisfier," says **Jennifer Dyrseth**, MSITAM, CHAM, CHAA, CAC, patient financial services supervisor at Olympic Medical Center in Port Angeles, WA.

These days, more people are trying to barter for healthcare. "The educated consumer is starting to expect discounts. I'm seeing facilities offer discounts of up to 20% when patients commit to satisfying some or all of their responsibility prior to service," says **LaTonya O'Neal**, principal with Chicago-based The Chartis Group and a member of the firm's revenue cycle practice.

Some hospitals offer flat rate payments for diagnostic tests (usually cardiac CT scans or ultrasounds) that insurance does not cover. The hospital receives immediate payment, and patients avoid receiving a bigger bill when the claim is denied.

"The trend is moving toward hospitals offering set rates for services where insurers typically do not cover the services, or for patients with high-deductible plans," O'Neal says.

With firm policies and scripting in place, discount-seeking patients are all treated the same. "If the process is tightly managed, prompt pay discounts can be a good thing for revenue cycle metrics," O'Neal says.

However, staff need to be ready to respond to impossible demands. At Olympic Medical Center, some people ask to pay Medicare rates. Others want to pay what they heard someone else was charged at a different hospital. "We are seeing strange requests for discounts come up, certainly," Dyrseth says. Here are some requests, and demands, registrars are hearing:

**• "Another hospital offered me a bigger discount."** This is actually a good ice-breaker. "It opens up a discussion about comparing discounts apples to apples," Dyrseth explains.

Hospitals offering bigger discounts might be charging much more to start with. Sometimes, the "cheaper" amount quoted by the other hospital omits some hidden charges. "Patients usually don't realize that hospital discount policies vary widely," Dyrseth adds.

Some hospitals offer discounts only if people pay ahead of time. Others allow discounted care at the time of service or even after the first billing statement goes out. "Some offer a flat discount. Others offer a higher discount for higher balances," Dyrseth notes. For instance, a hospital might offer a 20% discount on balances under $10,000, and a 30% discount on higher balances. Whenever patients mention other hospitals, Dyrseth notes Olympic Medical Center was designated as a facility offering the lowest prices in the state for many major medical procedures. "This educates people that we are not price-gouging," Dyrseth says. If someone does not qualify for a discount or for charity care, registrars give the reason. "I make sure they know it's not a personal decision, and that it's based on policies, laws, or tax codes," Dyrseth says.

**• "You gave my friend/neighbor/relative a better discount."** This is an especially common tactic in rural areas, where patients struggle for healthcare access. "You'll see patients communicating with each other about discounts," Dyrseth says.

Some people mention that a well-off friend with considerable assets received a large discount or some financial assistance. They want to know why they cannot receive the same discount. "Usually, their friend didn't share with them that they were struggling financially, or that they're self-employed and get to deduct expenses," Dyrseth says. If a patient brings up somebody else's supposed discount, registrars do not go into the account to check. They do not have permission from that other patient to discuss their income, family size, or other personal details. Instead, registrars take a "customer is always right" approach by not challenging the claim. "The instinct is to always trust what the patient is saying, or at least trust that the patient thinks that they know," Dyrseth says.

The registrar does not argue the point, and instead redirects the discussion to something more productive: what can be done for the patient they are working with.

**• "I want to speak to a supervisor."** If a hospital issues discounts on a case-by-case basis, that can expose the whole facility to more scrutiny, according to Dyrseth. A worst-case scenario: Registrars insist no discount is possible, but a higher-up grants it. "The message to the patient is that the front-end staff member is either lying, or doesn't know what they are doing," Dyrseth says. This only encourages people to demand a supervisor anytime they don't like the registrar's response. That hurts both revenue and morale. "Nobody wins in these cases," Dyrseth notes.

Ideally, registrars find a way to talk about other possibilities, such as loans or online payments. "We have found that the more options we have for patients, the more likely they are to pay their bill," Dyrseth says.

If discount demands cannot be met, staff encourage screening for financial assistance. "They usually qualify — for a bigger discount," Dyrseth says. ■

# Upfront Collections Processes Are (Somewhat) Upended

Upfront collections are a major focus for revenue cycle departments, with a strong emphasis on early financial clearance of accounts. Widespread unemployment and coverage loss has altered that for the foreseeable future, at least to some extent.

At North Mississippi Health Services in Tupelo, patient access staff used to set a clear expectation of payment up front. "The general message we convey now is, 'Whatever you can pay, we need for you to pay,'" says **Carol Plato**, vice president of revenue cycle. Registrars are seeing these groups of patients:

• **Some people want to pay up front and be done with it.** Registrars do not wait anymore for people to ask for discounts. "We tell everyone up front, 'If you pay now, we'll give you a discount,'" Plato reports.

If patients ask for a bigger discount than is allowed, staff keep it simple. "We explain that we cannot go outside our policy, and we are doing the best we can," Plato says.

The discount offered depends on the total. A bigger balance means a better discount. Discounts typically range from 5% to 20%. "It saves us statement costs and collection costs," Plato notes. "If the account got to a bad debt status, we would offer a discount anyway."

• **Many people are out of work, and cannot afford to pay anything.** Ordinarily, elective services would be rescheduled for this group. "We're taking everybody right now. We are not turning patients away like we might in normal times," Plato explains.

Charity care dollars are expected to increase significantly. Many patients say right from the beginning they cannot pay. "We get the process started," Plato says. "We note on the account that the patient appeared to need charity."

Registrars can always come up with some kind of solution as long as care is planned, even for high-dollar accounts. "The hardest group is when care is unplanned," Plato says. "They don't realize how expensive it is, and are unprepared to pay."

For patients presenting to the emergency department, the usual process is to collect at least copays. "Now, we ask — but we're not pressing it," Plato adds.

• **Some people cannot pay in full, but do not qualify for charity care, either.** For this group, payment plans usually are the best option. The department changed the way those are handled. Previously, the hospital paid a small percentage of the account balance to the vendor. "We only get 30 to 40 cents on every dollar of self-pay balances to begin with," Plato says.

That is because the odds of collecting after service (instead of at the time of service) drop dramatically. "In our situation, we have only about a 30% chance of collecting after the patient has received a statement," Plato says.

Accounts involving emergent care or large balances were the hardest to collect. To offset all the lost revenue, Plato's department recently switched to a different model. The vendor still sets up the payment plan, but patients pay a small monthly fee to continue with it. If the patient is paying $100 a month with a $4 monthly fee, the hospital receives $100 a month, and the vendor receives $4.

The hospital (eventually) receives 100% of the balance due. The vendor receives a small profit on each payment made, after statement and processing fees are covered. The patient can make small payments over a long period.

"Plans differ based on balance size, and will change if new balances are added to it," Plato says. The minimum payment accepted is $25, but plans go as long as necessary. "We find that patients pay off the balances sooner when they have a small fee associated with their plan," Plato observes.

However, when the account is resolved (with charity care, payment plans, or discounts), ideally, it happens up front. "Resources on the front end reduce denials, errors, and rebilling on the back end," Plato notes.

That means the central business office spends much less time chasing all the problematic accounts. "The more we get done at the front end, the less FTEs [full-time equivalents] we need on the back end," Plato says. ■

# Tools Say Patient is Eligible, but Only Dental or Vision Is Covered

Many registrars have excellent eligibility verification software at their disposal. Still, some responses are interpreted incorrectly. "Even though hospitals invest in technology tools, we are still faced with end user interpretation," says **Rachel Spoerr**, director of patient access at University Hospitals Cleveland (OH) Medical Center. Two factors make it harder to determine eligibility: lack of standardization of health plan insurance cards and inconsistency

in the way returned results are formatted. If insurance is verified incorrectly, it sets into motion multiple problems. No one notifies the payer of the patient's admission status within the required 24 hours. Authorizations and precertifications are missed. Bills are sent to the wrong payer.

"The patient could be out of network with no coverage or limited coverage, and increased out-of-pocket liability," Spoerr adds. All these mistakes end the same way: The claim is denied.

To keep it from happening, the hospital gives registrars plenty of exposure to all kinds of insurance coverage responses. During training, new hires take turns acting as patients.

"They enter information in the registration application and receive responses from carriers," Spoerr says.

Staff quickly realize how complicated it is. To be sure they understand properly, new registrars shadow experienced colleagues for three to six weeks. "Insurance verification is very complex. There are hundreds of different plans," Spoerr notes.

Usually, the problem is payer responses are incomplete. Eligibility responses from one large payer state coverage is "active," but fail to flag the patient's out-of-network status. This causes huge problems for the hospital. "The only way we know the patient is out of network is the presence of a tiny logo on the insurance card," Spoerr notes.

If the patient does not present the physical insurance card, there is no way to tell until it is too late. "Patient access is uninformed, and payment is compromised," Spoerr explains.

Other "active" coverage responses do not reveal the patient only carries vision benefits. "Patient access must understand how to read insurance cards and interpret contract status," Spoerr stresses.

Limited benefit plans with $100 or less per day inpatient coverage are becoming more common, too. The system does not flag the sparse coverage. "We must be very diligent to review all of the details," Spoerr says.

Misread eligibility responses mean surprise bills for patients, something nobody wants. "It creates rework for billing, denials, and ultimately loss of revenue," says **Maryann Heuston**, senior director of revenue cycle access operations at Cambridge Health Alliance in Malden, MA.

Some payer sites go down frequently, adding to the problem. Even if the sites are working correctly, eligibility responses can be deceiving. "Some responses say that the patient was eligible. But when you read the fine print, they really weren't eligible," Heuston says.

This happens with MassHealth (Massachusetts' Medicaid and Children's Health Insurance Program). Responses come back saying the patient is "eligible." Farther down in fine print, the response specifies the patient is "covered for dental services only."

To registrars, it looks like the patient is fully covered by Medicaid. "The quick reaction by the front-end user is to put that in as the coverage and move on," Heuston says.

Patients may carry old cards that are no longer valid. Health plans make changes restricting coverage during open enrollment periods. Either way, says Heuston, "people assume they are still covered for a particular service, but they no longer are."

Too many claims are denied because of these mix-ups. "We worked with our vendor contacts to come up with a way to alert the registrar that the patient is not covered for the medical visit," Heuston says.

After a system redesign, registrars receive more details on what is really covered. "It makes it easier to interpret so it's not a claim going out the door, and then we get the denial," Heuston says.

The system even tells registrars the specific action that is needed to confirm the patient's actual coverage. "It is quite unique," Heuston reports. "It will improve the accuracy of the data we are collecting related to insurance. We think this is groundbreaking." ■

# Feedback on Problematic Calls Comes from Coworkers, Not Supervisors

A supervisor says she received a complaint from a patient about rude treatment. She asks you, the registrar, whom the complaint is about, to listen to a recording of the call. Then, the supervisor asks if you think you provided good customer service.

This approach could lead the team member to become embarrassed and defensive — and could permanently damage the feedback loop between supervisor and employee, according to **Denise Williams**, COC, CHRI, senior vice president of revenue integrity services for Revant Solutions.

Some departments are using recorded calls for quality assurance differently. They are switching to a team approach. "We brainstorm as a group on appropriate responses when the customer's voice is indicating frustration or agitation," Williams explains.

After listening to a difficult call, the team discusses what could have been done better. "Sometimes, it's just a matter of choosing a different word," Williams observes.

Management always gives employees a heads-up before sharing a problematic phone call, since coworkers are likely to

recognize one another's voices. "This allows the team member to not be caught off guard with their less-than-stellar presentation," Williams says.

Usually, the employee acknowledges that was a bad day, something everyone can relate to. "Then, the team discusses strategies they use on a bad day," Williams adds.

Many recorded calls fall in the category of "moderately good" service. The calls start out OK, but end poorly. "It's usually because the customer is upset about something, and the team member responds in kind," Williams notes.

Staff may overhear a conversation that is going poorly in the next cubicle. Certain team members made a habit of standing and simply placing a hand on a stressed colleague's shoulder. "The gesture was enough to let the one on the phone realize that their tone of voice is changing, and that someone has their back," Williams explains.

Staff found a new way to do this even with social distancing. "They are helping each other via instant messaging," Williams says. Coworkers send an emoji with sunglasses or a few words (such as "time for a cool-down").

"The team worked out what each would say so that the recipient knew the context and watches for these reminders while on the phone," Williams says.

If registrars are working remotely, they cannot hear each other's calls. "However, they do have quick debriefing calls each day to talk about the calls that were frustrating," Williams says.

Another creative technique has evolved. When a caller becomes irate, the team member politely asks him or her to hold for a moment to conduct a little research. The original team member asks a coworker to take over.

"Together, the two team members briefly review the call to that point," Williams says. "Then a 'fresh' person gets on the phone."

Remote workers still can transfer tough calls to a willing colleague. They put the caller on hold, find out who is available, and give that person a heads-up that the call will be transferred to them. "A fresh voice is sometimes all that is required to get customer service back online," Williams suggests.

At Arlington-based Texas Health Resources, patient access employees participate in "call labs."

"A group of 10 gets together, with one call pulled from everybody in the room. Everyone learns from it," says **Alyssa McDonnold**, CHAM, former director of the health system's Patient Access Intake Center. Currently, McDonnold is patient access director at Maury Regional Health in Columbia, TN.

Feedback comes not from higher-ups, but from colleagues who perform the exact same jobs. "There's something about having another person say, 'I've had it happen to me, too,'" McDonnold says.

One recent call lab shared some examples of difficult interactions with people who could not pay their out-of-pocket liability. Instead of becoming defensive, staff really wanted to talk about the emotions involved with the calls. "The hardest part is trying to wrap it up in an hour because of all the interaction that happens," McDonnold says. ■

## COMING IN FUTURE MONTHS

- Patient access steps up to help the newly uninsured
- "No auth" claims denials — despite health plan waivers
- Registrars may misidentify "junk" insurance plans
- What new quality metrics mean for patient access field

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