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INSIDE

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Hospitals Need Patient Access to Financially Clear More Accounts — and Earlier

Financially clearing accounts earlier has never been more important, as hospitals' budgetary issues continue.

"Early financial clearance is the foundation of the patient access department," says **Alyssa McDonnold**, director of patient access at Maury Regional Medical Center in Columbia, TN.

A centralized preservice department handles scheduling, preregistration, precertification, and financial clearance for all three of Maury Regional Health's hospitals. "The key is keeping track of how many days out accounts are being worked — and how many of them are financially secured," McDonnold says.

That means insurance is verified, precertification is obtained, and some kind of payment arrangement has been made. The department's goals are twofold:

- For 90% of all admitted patients to be financially cleared at check-in;
- For staff to collect 30% of total estimated out-of-pocket charges.

"We are currently averaging 43%," McDonnold reports. "Our preservice department collected over $100,000 for the first time ever."

Preservice teams are assigned a day or date range for which they are responsible. Previously, a group of staff struggled to complete precertification and preregistration for all the next-day accounts. Now, employee 1 works all next-day accounts, employee 2 works all accounts two days out, employee 3 works all accounts three days out, and so forth. "This caused a divine balance in our preservice work flow," McDonnold says. "After a few weeks, the work flow evened itself out."

Before the new process, some patients did receive a call. The problem was it did not happen early enough to resolve the account before the service date.

"We hardly ever got beyond two days out because there was so much work for patients who were coming in tomorrow," McDonnold says.

Now, patients are called as they are scheduled, up to five days out. The daily "secured at admit" rate (meaning the account is financially cleared and authorization is in place) for preservice accounts averaged 62% at first. It recently hit 90%, and averages about 70%. The department fully expects the number to go even higher.

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Financial clearance of surgical accounts has become a top priority at Augusta (GA) University Health. "We are ramping up processes that will allow us to reach out to patients prior to their surgical date," says **Lee Patillo**, director of registration and preaccess services.

All of it used to happen only when the patient checked in for surgery, resulting in needless stress. Today, the process is completed days earlier. First, the surgery coordinator contacts the patient to verify demographic and insurance information. Concurrently, the patient learns the amount of copays and deductibles. "This process allows for patients to move through early morning registration efficiently with peace of mind," Patillo says.

If the process works as it should, patients do not receive surprise bills later because of unpaid claims. "Our initial first-pass denials related to surgical authorizations have been cut almost in half," Patillo reports.

An estimator tool calculates the expected out-of-pocket amount. The amount can change if additional codes are needed, but it is a starting point. "In general, it provides a basis that the patient can use for budgeting," Patillo says.

If clinicians select an incorrect code, the estimate will not be accurate. Recently, patient access worked with Health Information Management (HIM) to tackle this problem. A HIM coding representative reviews the clinical documentation before the surgical coordinator obtains the authorization. "Without this process in place, hospitals run a risk of inaccurate codes, which may lead to denials," Patillo says.

The department cut the number of "no auth" denials for surgical cases in half. Copay collections also have increased because of the preregistration calls. "The expectation is to double our current copay collection rate for scheduled surgical services by end of calendar year 2020," Patillo says.

Elective outpatient nonsurgical patients are preregistered at the same time they are scheduled at Naperville, IL-based Edward-Elmhurst Health. This is a recent change for the department. "We began reviewing patient liability and calling patients to review their coverage and any patient responsibility," says **Jim Economou**, system director of patient access and the preservice center.

Some patients self-schedule online. If so, they can simultaneously complete their preregistration beforehand. "We have been working on moving more automation to patient estimates," Economou reports. Patients are learning their out-of-pocket costs right at the point of scheduling. "This allows us to reallocate our resources," Economou notes. "We can focus on financially clearing more accounts." ■

Patients with Chronic Conditions Put Off Needed Care

Working with countless disabled and homebound older adults, **Namkee G. Choi**, PhD, sees many who live with no health insurance. After the onset of disability in their 50s, people could no longer work and lost their coverage. "Eligibility for Medicare and/or Medicaid is tough, and many did not have it for many years when they needed it the most," says Choi, chair of gerontology at the school of social work at The University

of Texas at Austin. More "near older" patients (age 50 to 64 years) with chronic health conditions are putting off needed care they cannot afford, according to the authors of an analysis.[1] Researchers found lack of coverage is a particular problem for this group, which lives with more chronic health conditions than younger groups, but is not old enough for Medicare. Their income, especially for those who still work part or full time, is too high to qualify for Medicaid.

Researchers analyzed data from 2013 to 2018, and discovered that near-older adults without health insurance were at least seven times more likely as other patients to have gone without needed care because of cost constraints. "The main takeaway was that if you're an older American without health coverage, you're going to have less access to healthcare," says Choi, the study's lead author. Other key findings:

• Many of these individuals still worked, but their jobs either did not provide healthcare benefits or paid too little to help employees afford better coverage (yet paid too much to qualify for other aid);

• The chance of living with no coverage was much higher among racial/ethnic minorities.

Diana M. DiNitto, PhD, another study author, says financial counselors can help direct patients without insurance to federally qualified health centers (outpatient clinics that receive funding to provide primary care services in underserved areas). By addressing acute and chronic care needs, the hope is these patients can avoid unnecessary ED visits or hospital stays altogether.

"This may take substantial effort on the part of counselors," says DiNitto, professor of alcohol studies and education at the University of Texas at Austin school of social work.

Local governments and community programs offer additional resources. In Travis County, TX, there is the county government-funded Medical Access Program for low-income people.

"Some of my low-income homebound older adult clients benefit from that," DiNitto reports.

Additionally, the Texas Adult Protective Services offers emergency community service funds that case managers can use for medications for older adults. This is helpful even if patients are on Medicaid. The number of medication prescriptions that a Medicaid beneficiary can fill per month varies widely among state Medicaid programs.

"In Texas, the number is just a few. Many older adults on Medicaid go without necessary medications," DiNitto observes.

Bryan Choi, MD, MPH, another study author and an assistant professor of emergency medicine at Brown University, says, "uninsured and underinsured people still have access to the healthcare safety net. But this isn't a substitute for full access."

Patients with comprehensive coverage can access all the care they need without incurring significant financial hardship. This includes primary care, mental care, prescription coverage, specialty care, and dental care.

"Specialty care and dental care in particular are things that the underinsured and uninsured have trouble obtaining in a timely fashion, from my professional experience," Choi shares.

For example, an ED physician can recommend that a patient see an oral surgeon for a fractured tooth. However, there may be no surgeons in the area willing to take Medicaid or certain "nonpremium" insurance plans. "Then that's a problem for that patient," Choi adds. ■

REFERENCE

1. Choi NG, DiNitto DM, Choi BY. Unmet healthcare needs and healthcare access gaps among uninsured U.S. adults aged 50-64. *Int J Environ Res Public Health* 2020;17:2711.

Registration Mistakes Can Harm Patients Clinically

Registration errors mean lost reimbursement for hospitals, but more than money is at stake.

If a duplicate medical record is created, "it compromises safety, could delay care, or could result in inappropriate care," says **Lorraine Possanza**, DPM, JD, MBE, program director of the Partnership for Health IT Patient Safety at ECRI.

It takes significant time and effort to combine records or remove inaccurate information.

"It is difficult to clean up incorrect records after the fact," Possanza says. "If the match is incorrect, then the errors cascade."

It is not only one patient who is at risk, but also the patient whose record was matched incorrectly. If wrong information is copied from another record, or if incorrect matching of the record occurs, "then it is impossible to have correct billing," Possanza cautions.

The costly mix-ups happen for all kinds of reasons: Patients with similar names, patients with "junior" or "senior" attached to their last names, or the names of husbands and wives are mismatched. "These errors can occur

anywhere and in any setting," Possanza observes.

Patient safety events involving registration "involve communication, documentation, tracking of patients, and the gathering and exchange of information," Possanza adds.

If the patient was billed incorrectly, and then arrives for a similar service, it causes lots of confusion. The insurance claim is denied because the record mistakenly shows the patient already received the service. "Billing an incorrect patient could also result in a false claim issue," Possanza explains.

ECRI recently received reports of some other patient identification issues:

• A patient came to the ED for a screening test, but their previous records did not come up. "The patient had been seen there previously, but the registrar thought it was a new patient," Possanza says.

This can happen because of how the registrar obtains the demographic information. Asking for the name, address, ZIP code, date of birth, and cellphone number is ideal. "Recording the information in a standard manner creates a better match," Possanza adds.

The address might be entered as Elm St., Elm Street, or Elm ST. The name might be entered as Tom Smith, Thomas Smith, Thomas A. Smith, or TA Smith. "Having additional information — for example, a cellphone number — may help to distinguish these individuals," Possanza suggests.

Sometimes, records cannot be located for whatever reason, and a registrar creates a duplicate record. "Later, someone has to spend time to merge the records or to pull incorrect records apart," Possanza laments.

Creating a duplicate record is more than just an administrative hassle. It prevents clinicians from viewing documented allergies, medications, or previous conditions. "These events really emphasize the importance of gathering information in the right manner, and completely," Possanza says.

Registrars can ask questions such as: "Are you giving me your legal name?" or "Is this the name that appears on your driver's license and insurance card?" Just because information appears on a screen does not mean it is correct or current. "It still requires verification, and potentially modification or updating," Possanza notes.

• A patient received a call about a positive COVID-19 test, when in fact they never underwent a test. "This reveals a problem with the exchange of information at registration," Possanza says.

The patient who received the call had not been seen recently. The patient who should have been called with the positive result had a similar name. Even though registration caught the error, deleting any information from the EHR is never easy. Therefore, it is possible the result remained in the incorrect patient's record, which could affect future care, Possanza adds.

• An uncle and his nephew had the same name, and their charts were mixed up. The mistake was discovered when the nephew, a child, was undergoing preoperative screening. The nurse asked about a condition noted in the record, and the mom insisted her child did not have the condition. At that point, staff realized they were using the wrong chart — the one for the uncle.

• A patient's Do Not Resuscitate Form was scanned into the incorrect medical record. "These are potentially dangerous situations where patient wishes may not be followed," Possanza warns.

It is important to correctly "match" the patient with the correct information, whether it is an allergy, medical history, current health condition, or wishes for care.

"This involves information-gathering, information-documentation, and information-matching," Possanza explains.

• Antibiotics were about to be administered intravenously to the incorrect patient. The order was written for a patient with the same last name but a different first name.

"In this instance, the nurse caught the error prior to the administration of the antibiotics," Possanza reports.

• A patient tested positive for COVID-19, but received the results by letter instead of phone. This meant it took several days to notify the patient. In this particular case, the patient underwent a procedure at an out-of-state hospital, then traveled back to their home location.

The problem was no one asked for the patient's cellphone number at registration. Since only the patient's address was in the chart, that is all the information available to staff.

• Registrars selected the wrong patient after putting in the first few letters of a last name and finding what seemed like a match. Drop boxes contain multiple patients with similar names. Sometimes, the names are exactly the same.

"This is not unlike the list of email addresses that come up when you begin an email and you are selecting someone to write to," Possanza offers.

Registrars quickly see that a name matches and just assume it is the person standing before them.

"When pulling up a record, they don't realize it is not the same person. Instead, they just move forward," Possanza says.

The problem may be the way the screen appears. Information is cut off, so registrars cannot view other pieces of data that would clear things up.

"The information can be verified with the individual," Possanza says. "That is the first step." ■

Departments Are Revamping Registration Identification Processes

Identifying the correct person at registration "ensures downstream systems have the correct clinical record," says **Brenda Pascarella**, CHAM, associate director of patient access at Albany (NY) Medical Center.

If not caught, incorrect patient identification can lead to administering the wrong medication or performing tests that were ordered for another patient.

"Ensuring staff is following the patient identification policy can prevent a wrong patient from being chosen," Pascarella says. Her department recently made two changes to this process:

- When searching for a patient, registrars use the first five letters of the patient's last name and the first two letters of the first name.
- The IT department added system prompts to alert registrars if they are not following the proper look up procedure. If the correct search criteria are not used, an alert states, "Training issue detected. Please adhere to the 5-2 rule."

"In addition, if the user hasn't found their patient in the system, the 'add new' button has been made red," says Pascarella, noting this makes it less likely the registrar will create a new record for a patient who was seen previously.

Diane Eck, a patient access manager at Middlesex Hospital in Middletown, CT, says, "an error in registration can delay treatment or result in improper treatment, which can be life-threatening."

If the incorrect patient is registered, clinicians will not be aware of allergies, and they will not have access to the medical history. "This could result in the patient requiring a higher level of care, or even death," Eck says.

If the incorrect address is on file, patients who arrive via ambulance from skilled nursing facilities could be transported to the wrong address. If the incorrect phone number is listed, tests ordered for ED patients may return after the patient is discharged.

"Should the phone number be incorrect, we have no way of contacting the patient," Eck says. "They may be in need of immediate medical care."

To prevent all of these errors, registrars use two identifying factors (name and date of birth) and ask the patient to verify the spelling of both their first and last names. Engaging patients by asking for their information instead of just reading it to them is especially important.

"You may not have their full attention. They may just agree with everything you have said," Eck offers.

Additionally, registrars verify all information without skipping any fields. "If there is a field to fill in, it is important," Eck stresses.

Accurate registration processes can prevent an allergy or drug interaction. "It is also about protecting patient financial and personal safety," says **Karoline Pierson**, director of patient access at North Memorial Health in Robbinsdale, MN.

Staff can prevent registration errors (e.g., creating a new medical record for an existing patient or pulling up an incorrect patient file) by understanding cultural variations in name spelling or order, using multiple data points to verify identity, and asking open-ended questions.

"Ongoing training on all of these elements — and a prompt review when errors do occur — builds a culture of accountability," Pierson says. ■

Coworkers Share Tips for Staying Calm if Caller Yells

Keeping cool when someone is shouting at you is not easy, but it is certainly part of the patient access role. Recently, **Denise Williams**, COC, CHRI, led a group meeting on how to remain calm under trying circumstances. Staff listened to this recorded call:

Caller (calmly): I just received my statement. I need to know why I received a bill from the hospital asking for payment from me. The hospital must have billed something wrong, and I need that corrected.

Team member (calmly): In reviewing the notes, your insurance company says your contract does not provide coverage for this specific service.

Caller: That is wrong. My doctor said it would be covered. The hospital must have done something wrong when the claim was filed.

Team member: I see that your doctor's office called and spoke with the insurance company prior to the service, and there was a precertification number provided.

Caller (interrupts and voice is raised): See! It was covered, and the hospital messed everything up!

Team member (trying to remain calm): A precertification number is issued based on the information that

was provided prior to the service. It indicates the insurance company was contacted prior to the procedure. It doesn't guarantee that the insurance will pay 100%. That is dependent on the terms of your contract coverage. If something changed during the service, that could change the amount of coverage provided by your insurance.

Caller (yelling): That is a crock! You are just trying to cover up the hospital's error and make me pay more than I should have to pay!

Team member (trying not to get defensive): No, ma'am, we are not. We work from the information that your insurance company provides to us based on your contract. You need to check your individual policy. I will ask our coding department to review the documentation again as a double-check.

Caller (loudly): Just fix it! I don't owe you anything, according to my doctor!

"We took this conversation and dissected it," says Williams, senior vice president of revenue integrity services at Raleigh, NC-based Revant Solutions.

Coworkers agreed their colleague said all the right words. Yet it was obvious the employee still was not able to defuse things. "We need to recognize when a caller's voice is rising and be sure that our voice stays calm and serene," Williams says.

Employees shared their own personal tricks to accomplish this:

- Think about sitting on the beach;
- Imagine every caller as a parent and the consequences of "back talking";
- Squeeze a stress ball;
- Take a deep breath, and say to oneself: "I will not get upset. He/she doesn't understand what I understand."

"The team member involved in the call was grateful for the insight, and hadn't considered these," Williams reports. ■

Registrars Counter Rising Tension with Calmness, Kindness

Constant changes during the pandemic have escalated the amount of tension in registration areas.

"We have had many families struggle with our visitor restrictions, virtual waiting room, temperature screening, and appointment availability," says **Emily Robitaille**, a patient access employee at Connecticut Children's. Here are some common scenarios:

The situation: Parents arrive for an appointment, and find out they owe a large amount. They complain that nobody told them.

The solution: Registrars assure the family they do not need to pay the entire amount, and can make a small payment, says **Kayla Dlubac**, a registrar at Connecticut Children's.

The situation: A parent comes in at their scheduled time for an MRI, but still ends up in the waiting room. "The family is unaware of the process," Dlubac says.

The "table time" for MRIs are different than the appointment time to allow for registration paperwork or prepping for anesthesia.

The solution: Registrars apologize for the long wait, and try to explain the reason why the family was asked to come in early. The registrar goes back to speak directly with the MRI technicians or sedation nurses to ask how much longer the wait will be, Dlubac says.

The situation: Families are upset about restricted visitor policies, which allow only one parent to come in with the child, and no siblings.

The solution: Registrars go to the manager to see if an exception can be made. Sometimes, both parents or siblings can go in since they weren't told of the policy in advance. "When in doubt, we apologize and show the families that we understand their emotions," Dlubac says.

The situation: There is some kind of unpleasant surprise. "Often times, families show up and have no idea what department they are seeing or what the appointment entails," Robitaille notes.

The solution: Remaining available can make a big difference to people. Registrars initiate the conversation first with a greeting or a smile. If registrars do not know the answer to a question, they take the time to help people find someone who does. If the family does not know where they are going, registrars physically walk them to the destination. "In all the unknowns of what they have to deal with — new policies, directions, test results, or insurance issues — we can be the constant that helps them navigate that experience," Robitaille says. ■

COMING IN FUTURE MONTHS

- Dramatically cut no-shows by offering patients a ride
- Role-playing for the toughest financial conversations
- Coding mistakes are causing valid claims to be denied
- Payers are refusing to reimburse for in-hospital services

Identify a Registrar's 'Pain Points,' and Fix Them Fast

At Miami-based Jackson Health System, daily huddles serve two purposes. Registrars receive updates on departmental changes, and leaders receive updates on what is going on with employees. "Staff get to voice their 'pain points,'" says **Melissa Moreira**, director of eligibility and patient access. Supervisors do more than just listen; they always follow up the next day on what action has been taken on the issue.

When staff first started working at home, the biggest complaint was lack of ability to scan or fax documents. Staff believed they could not perform their jobs without this capability. Managers quickly implemented an electronic faxing tool, and taught staff to upload documents directly into the medical record. The new process turned out to be easier. "Staff were much happier, as this saved them time," Moreira reports.

The department is creating a virtual "Huddle Board." This will include a mechanism for staff to write their proposed ideas, and for managers to answer them. "Staff really appreciate the feedback loop," Moreira says.

Quick answers are not always possible. Some issues take longer to resolve because outside entities, such as insurance companies, are involved. "But since the item remains open, it's a way for leadership to continue to pursue the issue until it is closed out," Moreira notes. To do something about what annoys staff, supervisors need to know about it. "As leaders, we have an obligation to not accept the status quo," says **Ralene Cosby**, corporate patient access director at Brookwood Baptist Health in Birmingham, AL.

When walking through registration areas, patient access leaders continually ask the question, "Is there a better way?" These are some recent examples of how leaders fixed problems for staff:

• Preregistration staff used dual monitors, but they were of such small size that it was difficult to view the screens. Because of personnel changes in the organization, many widescreen monitors suddenly became available. "With no additional cost to the department, we were able to give each preregistrar at least one widescreen monitor," Cosby reports.

• Some payers still require faxes for authorization requests, so staff wasted lots of time printing and faxing documents. "We inquired if IT had an electronic solution," Cosby recalls.

It took just one phone call to find a solution. Patient access gave a list of contacts to IT, and IT loaded the information on each workstation. Something that caused endless frustration was surprisingly simple to fix. "It was a 10-minute task," Cosby says. "This easy, no-cost solution had the added bonus of saving paper — at least a case a month — and toner expenses."

• The analyst responsible for patient estimates reported that lack of access to information was causing inefficiency. The analyst was proficient in the Medicare Ambulatory Payment Classifications and the Blue Cross Enhanced Ambulatory Patient Group reimbursement system. "But there were often fee schedule-based rates that she had to refer to the contract team," Cosby says.

The analyst wanted view-only access to this information, and IT found a way to provide it. "She could handle more accounts without assistance and felt more empowered in her role," Cosby says.

• Staff were disappointed when Patient Access Week (which normally occurs in April) was canceled because of COVID-19. This event is something that all patient access departments and the centralized business office really look forward to, Cosby says. Leadership planned an event at the end of the summer to recognize the team's hard work, with a "Golden Girls" theme. Registration areas were decorated, and door prizes were given daily for word games (scrambles and crossword puzzles). Lunch, snacks, and candy were offered.

The department had a small budget available to cover costs, but most of the expenses were paid by the leadership team. "The team was so appreciative, not only of the gifts received but also how much effort was put into the events," Cosby says. ■

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