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INSIDE

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As a staff's comfort level soars, so does the rate of its collections

Role-playing customer interactions made the difference

When **Evelyn Gullet**, MBA, became director of patient access at University Medical Center in Lubbock, TX, a little more than a year ago, no collections were being made at the point of service. The overriding obstacle to any such effort, Gullet found, was registrars' fear of what they anticipated would be an unpleasant experience.

Registrars didn't like the idea at all, she says. "They didn't know how to overcome resistance or aggressive behavior [on the part of patients]." Part of the reluctance, Gullet notes, was because the not-for-profit hospital is a county facility, where the whole concept of collecting money seemed alien.

When the hospital administration asked her to spearhead an effort to collect copays and deductibles at the point of service, Gullet asked her staff how comfortable they were with the idea. The response, she says, was that they didn't feel comfortable at all.

After an extensive inservice on the ins and outs of collections and the opportunity to get some experience under their belt, the staff's confidence has soared along with the collection rate, Gullet says.

Special Report: Upfront Collections

In this issue, *Hospital Access Management* takes a look at how three facilities are getting a handle on upfront collections. With hospitals continuing to face dwindling profit margins, getting payment at the beginning of the revenue cycle — not months down the road — can make a crucial difference to the bottom line. Access managers are well-positioned to become heroes to their organizations as they take the lead in this effort. ■

Since the effort began in October 2000, in the outpatient surgery department, the amount of copays collected up front has gone from zero to about $25,000 per month, she adds. "Most of the time, people pay the entire amount, or at least 50%. I'd say 85% pay the whole copay." Patients who say they can't afford to pay are referred to financial counselors, who check to see if they qualify for government assistance, Gullet says.

The two-hour inservice, which included several role-playing episodes, made the biggest difference in the registrars' attitude toward their new responsibility, Gullet says. The participation of hospital employees from other departments in the role-playing exercises was particularly effective, she notes. It helped registrars to try out questions such as, "Would you like to pay by cash or credit card?" and "How much can you give us today?" with people they didn't know well, Gullet adds.

An effective collections program, however, is not just about the registration employee, she points out. "It's also about the community. People have to get used to it." For the most part, Gullet says, that has happened, even though there has been no educational effort, such as running ads in the newspaper announcing the new policy.

Perhaps the biggest contributor to the successful collections effort, she notes, was choosing the right employees in the first place. Since assuming her position, Gullet says, she has replaced at least 10 of 17 employees in the emergency department (ED) business office, including the manager, and five of eight outpatient surgery employees, also including the manager.

Gullet's focus in hiring, she explains, is on whether the person has a customer service background and the core skill of being a communicator and a listener. "I can teach them the other things [involved in being a registrar].

"I want to know if they can deal with the [hospital] environment, because it can be very, very stressful," adds Gullet. "They're working not in a hotel, but in a hospital. Family members can be emotional."

When screening potential employees, she says, Gullet asks "What would you do if . . .?" questions to determine if the person is right for the job. "I've worked with people who had Harvard degrees who couldn't do anything for me," Gullet notes.

Although she lets her manager handle the initial stages of hiring, she says, Gullet always meets the person, reviews the resume, and asks a few questions herself.

In May 2001, Gullet says, she extended the collections effort into three ancillary registration areas — radiology, physical medicine, and the cancer center. Although the employees who register in those areas do not report to her, Gullet supports their efforts with training and role playing, assisted by a training analyst who works for her.

"We talk about what works and what doesn't work," she says, "and customer service is a big thing. We are making [the collections effort] a friendly competition. Once they've experienced success, once they've made their first collection, it's amazing what it does to the motivation."

It's important, Gullet emphasizes, that she and the trainer provide continuing support with plenty of positive reinforcement. "I send [complimentary] e-mails and cookie bouquets. My experience in other industries is that lots of things people do go unrewarded or unnoticed. They're trying so hard and doing a wonderful job."

The next level is encouraging the staff to be creative and team-driven, she adds. "It's not one person being the highest collector. There should be a team goal and a team reward."

ED poses unique challenges

Key to any collection program in the ED, Gullet points out, is a physical layout that promotes an efficient flow of traffic. At her facility, for example, there are two main hallways leading in and out of the ED, which has 28 rooms and sees some 56,000

patients a year, she says.

"We've tried to create some kind of flow to get patients to see our discharge people and have that financial conversation at the end of the visit," Gullet notes, but she says it's easy for patients to go out a back door without being noticed by the busy staff. The addition of double doors at the formerly open entrance to the ED, however, has provided some structure, Gullet adds.

Eventually, she says, "we want to have patients automatically pass the discharge counselor. To be successful, you want to keep them in one area, and you want to be in charge of delegating their flow. We're working toward that, and I have made several written recommendations. I'm trying to benchmark with colleagues and back it up with numbers."

With the less-than-perfect ED layout that is the reality for most facilities, though, it's important to educate the clinical staff on the importance of leading the patient through the process, from triage to some sort of financial resolution, she suggests. "If people walk out the door [without paying] and they've had exams, been given durable medical equipment, that adds up.

"We're working on it, but we're in our infancy," Gullet says. "It's a real challenge. Sometimes I think, 'Doesn't anyone understand where their check comes from?' I meet with the [ED] nurse manager, attend her staff meetings, and try to explain to people what a difference this makes to the bottom line." ■

Need support for copay? Back it up with the figures

Security concerns were initial obstacle

If you are interested in instituting a program for upfront collections, it's a good idea to have some financial evidence to give credence to the proposal, suggests **Ellen Byrne**, RN, MS, director of patient access services at Community Medical Center Healthcare System in Scranton, PA.

In her hospital's case, Byrne notes, the business office did a report on managed care patients they had billed for copays after a visit to the emergency department (ED). "They tracked who paid and who didn't," she adds, "and the director of the business office estimated [the hospital] was losing $50,000 a year from those who never did pay."

As part of the hospital focusing attention "wherever money was being lost," Byrne met with a group that included her supervisors, the business office director, the vice presidents of finance and operations, the ED nurse manager, and representatives from security to consider beginning a collections effort at the point of service.

Security personnel were included, Byrne explains, because the main objection being expressed about collecting money in the ED was that registrars might be held up. "The safety of registrars was really the whole concern," she says.

"We met and met and met, with everyone voicing concerns," Byrne adds, "but it reached a point where I finally said, 'We just have to do it.'"

With the decision made, the financial advisor — who reports to Byrne — sat down with ED registrars and went over the procedure, she says. "The financial advisor was knowledgeable about [collecting copays] because she was here when it was tried before.

"[The supervisor] explained the process of how to pose the question — 'How do you plan to pay?' not, 'Do you plan to pay?' It was a one-on-one orientation," Byrne adds. Because of the security concerns, the payment choices initially offered were check, Visa or MasterCard, but cash also is accepted now, she notes.

Paying up front

The collection process, implemented in October 2000, is going well, says Byrne, who was awaiting a report from the hospital's finance department on exactly what improvement has been made. "The staff have been great and the patients have been great," she adds. "Some have offered to pay at the point of registration."

With the help of Washington, DC-based Hworks, which calls itself "an advisory board company," Community Medical Center is looking at the entire revenue cycle, Byrne notes. Collecting at the point of registration is one subset of that effort, she says.

One of the pieces of the ED collections process the hospital still is working to perfect, Byrne says, is finding a way to ensure that the patient stops

to settle the account before leaving the facility.

"We're now looking at the process from front to end," she explains. "We inform the patient at the beginning [about the payment procedure], but we don't collect until the end. The problem is we have two entrances, so the patients can slip out, or there may be a delay at the registration area so they may not want to wait. There's no process to do a second check [to determine] that they did stop."

The plan, Byrne says, is for the hospital to use Wellsoft, its integrative clinical management system, to alert registrars and nurses that a copay is needed from certain patients. This on-line tracking system — which is displayed on large monitors in the ED — will color-code these accounts, she adds. Registrars will go to those patients and complete the discharge process before they leave the exam room, Byrne notes.

"Our goal is to have everything go back to the patient," she says. "I want to have a cart with a laptop, a receipt receptacle, and maybe a camera that can take a picture of the insurance card."

Another possibility is hiring a financial counselor for the ED, she says. That person, who likely would work a 1 to 9:30 p.m. shift, Byrne adds, would handle a variety of duties associated with self-pay patients. ■

'No pressure,' AM says, as copay collections rise

HMO 'resource book' aided effort

"Just ask" appears to be the operative phrase at Boulder (CO) Community Hospital, where the access services department increased the amount of monthly copays collected by more than $50,000 between March and May.

"It was one of those epiphanies," notes **Jill Mathews**, access services manager. She says the collections effort began in earnest after the department trainer volunteered to fill in for an absent emergency department (ED) registrar. "[The trainer] worked about six hours and asked everyone who came in for a copay," Mathews adds. "That's what she trained people to do, so that's what she did. Everyone paid, and she collected hundreds of dollars. She was shocked at how many said, 'No problem.'"

Up until that time, the hospital had been taking in about $22,000 a month in copays, but had not made collections a real focus, Mathews explains. Much of that money was collected, she notes, because patients said, "I think I have a copay."

After the trainer's experience, Mathews decided to see what her staff could do. As a result, collections increased from $22,000 in March to about $50,000 in April. In May, the staff collected $77,000.

"There was no punitive suggestion," she points out. "It was, 'Let's just see what happens.'" Mathews promoted the idea through group e-mails and at staff meetings, and offered a prize — a gift certificate to a bookstore — to the person who collected the largest number of copays.

When staff told her they felt bad about asking people for money in a health care setting, Mathews says, she emphasized that they are actually providing a service.

"If we ask at the [point of registration], I told them the patient won't have to write a check later and put that check in the mail," she adds. "Of course if they can't pay, they will still get the service, but some people appreciate doing it up front. They don't have to worry about figuring out what the bill is down the road."

Mathews says she also uses the supermarket example. "I make the joke that you don't go to the supermarket, get a load of groceries, and say, 'Just send me a bill.' The cashier at the supermarket doesn't feel bad for asking you to pay."

Although it's time-consuming to tabulate the results for each registrar, the friendly competition provides a challenge, she says. "It's important to validate for people that they're doing a good job and to make sure that they know you appreciate it, but that it is part of the job.

"I continue to raise the bar for folks," Mathews adds, "to say, 'Let's see if we can collect more next month.'" The same ED registrar won the competition in both April and May, she notes.

Doing the research

The way the payment process has worked in the past, Mathews says, is that a patient comes in and receives the service, the account is coded and

sent to the billing department, which then bills the insurance company. The insurer sends an explanation back, stating that it will pay a certain amount and the patient copay is this amount, she adds. If the patient has moved during that period or provided a bogus address, the chances of collection plummet, Mathews points out.

As part of the new emphasis on collections, the access staff did research to determine exactly how much the copays were for patients with Kaiser, with which the hospital does a lot of business, and for those associated with other HMOs, Mathews says.

"We wanted to show what the copays are for the different departments," she says. "The ED is simple, but for the other [outpatient services] I had my assistant call [the HMOs] and say, for example, 'Do you have a copay for an MRI [magnetic resonance imaging]?' We compiled that data and now have an admissions resource book for each staff member to use at the point of service."

She found out, Mathews says, that most HMOs don't require a copay for imaging or for laboratory procedures.

Copays are collected in advance for inpatients as well, she notes. "The financial counselor calls the insurance company and asks what the copay is when the patient comes in. Then the staff ask for copays as people are leaving the hospital. By that time, the financial counselor has entered [into the computer system] what the copay is." ■

Pay now or pay to park, UTMB patients are told

Hospital changes 'free care' image

Registrars at the University of Texas Medical Branch (UTMB) in Galveston have a built-in incentive for patients to stop and pay the bill on their way out of the emergency department (ED): If they don't, they'll likely get stuck with a $15 parking fee.

In place about a year and a half, the parking policy is one part of an initiative that began about five years ago, says patient access supervisor **Betty L. Avery**, CHAM, when UTMB put out the word that it would no longer be the facility where everyone comes for free care.

The way the process works, Avery explains, is that after patients receive treatment from ED clinicians and get their discharge instructions, a nurse escorts them to the registration area. "They see the registration staff, who verify demographic information and collect any copays or deductibles that are due." If appropriate, she adds, staff can screen the patients at that time to see if they qualify for financial assistance.

Although patients don't have to park in the ED garage, it's by far the easiest and most accessible option, Avery says. Otherwise, they can park some distance away in another hospital lot, or park on the street, where they risk getting a ticket, she notes.

Formerly an open area, the ED garage now is gated, Avery explains. There is a large sign at the entrance stating that it costs $15 to park there, and that a token allowing free parking can be obtained from an ED registrar, she says. "To get out, they have to pay or put in the token."

Setting agendas

In addition to boosting the hospital's bottom line, the policy also helps ensure that patients' follow-up appointments are made, Avery points out. Before, she says, patients might have been told to arrange a clinic visit in two weeks, but instead of scheduling the appointment, would simply show up at the clinic. Now the appointment is made at the registration desk when they check out, Avery says.

Several years ago, UTMB Galveston "was almost at the point where it might have to close its doors," she notes. To change the public's mindset that it was a charity hospital, UTMB "did a lot of advertising in the newspaper, and put the word on the street that we were in the red," Avery adds. "The community knew that there had been layoffs at the university and that measures would be taken [to improve the hospital's financial health]."

At that time, the hospital instituted the Demand Access Management Program (DAMP) for its indigent patients, she says. Calls from patients who don't have insurance or some other form of third-party assistance are routed to DAMP, Avery explains. Employees ask the callers about their

income, number of dependents, and other factors, and let them know if they might qualify for financial assistance or a discount from the hospital, she adds.

Patients are told to bring documents supporting that information to their appointment, Avery says. When they arrive, they meet with a financial counselor, who does a screening to see if they meet the criteria to receive Medicaid, or to participate in the hospital's sliding-scale fee system, she adds. "The patients have the mindset before they get here that they can get assistance."

If a discount is arranged, it is good for six months, Avery says. That means that if the patient makes a visit to the ED during that period, registrars can access the information in the computer, simplifying the registration process. At the end of the six months, participants whose status hasn't changed can bring in the same documentation to renew their discount, she notes. If the person's situation has changed — due to the birth of a child, for example — he or she may qualify for a further discount.

The minimum contribution required from any patient is $12, Avery says. "It's like their copay."

[For more information on their collections programs, you can reach Evelyn Gullet at (806) 743-3394, Ellen Byrne at (570) 969-8196, Jill Mathews at (303) 440-2012, and Betty Avery at (409) 747-8899.] ■

Incomplete orders down, thanks to access efforts

Worst offenders are targeted

A little more than a year ago, the access services department at Meridian Health System, in Neptune, NJ, began taking aim at reducing the number of patients who come through ambulatory care services without a complete physician's order.

The results have been dramatic, says **Julie Hamill**, RN, supervisor of access services, thanks to efforts by a physician liaison, visits to office managers, a regular luncheon for physicians' staff, and an instructional folder called "New Directions." **(See how another access manager solicits physician cooperation, p. 91.)**

"The effort began about March of 2000, and we saw a difference in the numbers in June," she says. "The percentage [of incomplete orders] went down and is now down to about 6%."

Traditionally, the access services department had a problem with physicians not putting a diagnosis on the order or, in the case of managed care accounts, failing to obtain a referral or an authorization for the procedure, Hamill explains. As patients arrived with an incomplete order, she adds, access employees would have to ask them to wait while someone called the physician's office, explained the problem, and asked that a revised order be faxed to the hospital.

A backlog of patients was created as all this faxing took place, particularly since the hospital scheduled procedures beginning at 7 a.m., and physician offices typically can't be reached until later in the morning, Hamill notes. When the hospital began keeping statistics and realized the number of patients who came in without the proper material for a registration, she says, her department took action.

Making it easier

After compiling a list of the worst offenders among physician offices, Hamill says, access services personnel decided to put together a New Directions folder for physician office staffs, with all the information and forms a patient needs to have a successful registration encounter. "Everything is reproduceable for the patient," she adds.

The folder includes five sections, Hamill says, which include:

- Patient instructions regarding tests and procedures.
- Master order forms for the most common laboratory tests and ICD-9-CM codes to help access staff match code and diagnosis. Physicians can use these forms for their orders, she explains, checking the appropriate box, or writing in the information for less common procedures.
- Department guide with information on where to park, where to register, and where to go for the service being performed, including which building and which floor. "We wanted the patients to know that before they came to the hospital," Hamill adds.

• Campus parking map.

• Directions and a map showing how to get to the main campus, Jersey Shore Medical Center, or to one of the other Meridian Health facilities.

"After we put this folder together, we took our list of 'worst offenders' and made physician office visits," Hamill says. "We called and asked for an appointment to speak with the office manager."

During the visit, she adds, the access representative explained that it is required by law that a diagnosis be provided before a patient is registered, and with a managed care plan, that certain procedures also need an authorization or precertification.

Less resistance

The office managers were "very receptive" to arranging the meetings, Hamill says, because they also had concerns. "Some were confused as to what plan needs what. When we spoke to them, in some cases, it created a healthy relationship. We didn't meet as much resistance as I thought we would."

In addition to these appointments, the access staff also arrange office manager luncheons, where they review insurance plan requirements, and continue to emphasize the importance of physicians' providing diagnoses on their orders, she notes. "We still have the 6% [of incomplete orders]."

Meridian Health has two physician liaisons, Hamill says, one of whom specializes in outpatient matters and helps present registration concerns to the physician practices. "I meet with the physician liaison, say, 'We're still having a problem with this group or this physician or this office.' She will address [the issue] in a medical staff setting or go to them one-on-one."

Patient education is another important facet of the physician compliance effort, Hamill points out, and it's aided by the distribution of materials in the New Directions folder. "With this packet, there's a page that tells the patient, 'This is what you need to bring to the hospital, this is the time you should arrive, and you should know your insurance company and authorization number.'

"We're hearing from the physicians' offices that patients are beginning to say, 'Do I need a referral?' or 'Do I need an authorization?'" she says. The patients are learning from experience what is needed at the point of registration, Hamill adds, and in some cases are taking an active role in making sure they have it. ■

Access airs concerns while staff get lunch

Physician offices stay in the loop

A monthly luncheon for physician offices hosted by Morton Plant Mease Hospital in Safety Harbor, FL, offers a forum for access concerns and helps smooth relationships between hospital and physician, says **Cathy Tammaro**, CHAM, manager of patient access services.

"If I have something new in access to share, or something they're not doing the right way, or want to praise them for doing something perfectly, I can do that," Tammaro adds. "We fill out a comment sheet every few months with hot topic ideas."

Get everyone together

One of the positive results of the luncheons — reinstituted near the beginning of 2001 after having been discontinued some years back — has been the ability to put a face with a voice or a name, she says. "If I'm arguing on the phone with some lady named Ann and then I meet that person, we have a tendency to be softer to one another. We're building relationships."

The meetings are held from noon to 1 p.m., the hospital provides lunch, and attendees may be office managers or front-desk supervisors, Tammaro notes. "We try to get someone there who sets standards."

The person in charge of physician relations and special projects for Morton Plant Mease and another smaller hospital in the Baycare health system chairs the meeting, she says. Baycare's larger hospital hosts its own office manager luncheon, Tammaro adds.

"The hospital will let them know what we're doing — that we have a construction project to add 100 beds, for example, or that we've made headlines for something," she says. Guest speakers from different areas of the hospital cover a wide range of topics, Tammaro says, from infection control to ergonomic evaluations. Office managers "feel like they're being kept in the loop."

When she stands up at the meeting to speak on behalf of access services, as she often does, Tammaro says, she is careful "not to pick on one office," but to make her comments general. "I'll say that we're getting prescriptions without a

diagnosis, or with a diagnosis that doesn't meet medical necessity," she adds, "or tell them that sometimes they're giving us codes when we need words. We go over things like that."

In some cases, Tammaro smoothes the way for an access policy, such as the requirement that ultrasounds will be cancelled if authorization isn't obtained the day before. "I ask them how I can make it easier" for the physician offices to comply," she says. "It seems to be working, but not every physician's staff comes, so we still have problem offices."

(Editor's note: Look for more example of how access managers are gaining cooperation from physicians' offices in the next issue of Hospital Access Management.) ■

Consolidated billing can smooth operations

Hospital, physicians share patient data

It's looking an awful lot like the future at Heartland Health in St. Joseph, MO, where billing for the hospital and its 14 medical group physician practices has been consolidated and centralized and all entities share a master person index (MPI).

"We share the same medical record number," says **Cheryl Field**, CHAM, patient access team leader. "When a patient is registered at the physician's office, the information is stored on the registration level of the [Eclipsys] system, which all entities share.

"Transitioning the physician offices to our hospital system [scheduling, registration, patient accounting, billing, and collections] has really been our big achievement," Field notes. "The physician office obtains demographic and insurance information during the patient visit. When the patient arrives at the hospital, we rely on this information and do not replicate patient demographic and insurance questions."

Heartland was to have been implemented on Aug. 1, 2001, an on-line process for monitoring rejected and denied claims that are precipitated by registration, coding and billing errors. The hospital and clinics will share this on-line process, she adds, to ensure the accuracy of the access processes and reduce rework during the billing cycle.

The sharing of information via the MPI and the merging of hospital and clinic billing has been facilitated, Field says, by Heartland's use of products from Boston-based software vendor Eclipsys for scheduling, registration, patient accounting, billing and collections. Heartland's clinical order-entry system is TDS, which has merged with Eclipsys, she adds.

"When a patient is registered for a visit in the hospital, the information reflects on the clinical side as well," Field notes. "The sharing of the information on the system allows the clinical and financial employees to work closely together."

"Eclipsys Sunrise is the software product that enables physician offices and the hospital to share information on the registration level," she explains. "An additional level, the 'visit' level for the hospital or 'encounter' level for physician offices, contains information on the specific visit," Field adds. "This information is kept separate for each entity."

Follow the audit trail

One of the system's most helpful features, she says, provides an audit trail whereby any changes made in the registration level can be retrieved and viewed. When a correction in a Social Security number or a patient's date of birth is made, for example, both the old and new value will be seen. "For any demographic changes, Eclipsys shows the date, time, the initials of the user who made the change," Field says.

This function allows Field to review access representatives' work and determine who is responsible for a particular error, she points out. "If someone says, 'This isn't accurate. How did you get this?' With audit trail tracking, I can see that the information was put in at this time by this person." This capability is particularly helpful with changes in insurance, Field notes.

Heartland's process for monitoring rejected and denied claims, she says, works as follows. When a claim is denied by the insurance company and returned to the hospital, the mail clerk receiving the denial enters the date and the denial code or reason for the denial from a menu of codes / reasons into an access file, Field explains.

"We've mapped each denial code to the appropriate area, such as access, billing, coding, etc.," she adds. "A designated follow-up person for that area can retrieve [the information] on-line to review or print a work list."

The follow-up person reviews the Eclipsys

audit trail to see the user ID of the access representative who registered the patient, Field continues. If, for example, the denial reason was "ineligible on date of service," the follow-up person determines that the access representative did not check insurance eligibility, she indicates it is a valid denial and assigns the responsible rep's name to the error.

"The rep [who made the mistake] can go in later and bring up her own report so that she can review comments, the reason for the denial, and know what she did wrong," she says. "At the end of the month, each access representative prints out her list of denials and signs it, indicating that she has reviewed the denials and gives it to her supervisor," Field adds. "That way, we have a record that she's getting the feedback."

The denials can be grouped by financial class: Medicare, Medicaid, or commercial claims, she notes. "This helps identify if there is a specific payer we want to target for additional education."

An enhanced list

Many of Heartland's innovations, Field points out, are a result of its active role in the Eclipsys Users Group. "We strive to maximize the capability and capacity of software applications."

Heartland submits enhancement requests at the user group meetings, she adds. After being prioritized, the list of enhancements is presented to Eclipsys, which evaluates the feasibility of implementation. Heartland has been able to improve its system functionality by using that approach, Field notes.

An endeavor on Heartland's horizon, she adds, is implementing Envoy, the Eclipsys product for on-line eligibility verification. ■

ACCESS FEEDBACK

Maine hospital reports pre-reg consent success

In the July *Hospital Access Management*, **Liz Kehrer**, CHAM, manager of patient access at Centegra Health System, McHenry, IL, asked her access colleagues for feedback on how they get consent forms signed when the patient is preregistered for a service.

"Where are the consent signatures being obtained?" Kehrer wanted to know. "Is the patient presenting at a 'quick check-in' desk or going straight to the department where the service is being performed?"

And if patients are reporting directly to the treatment area, which is often being done to expedite the process, who collects those signatures?

In response to Kehrer's query, **Francis A. Wren Jr.**, CHAM, director of access management services at Eastern Maine Medical Center in Bangor, shared this description of how his facility handles the process.

"We will preregister approximately 120,000 outpatients this fiscal year at Eastern Maine Medical Center," Wren wrote. "Patients report directly to clinical departments, where receptionists obtain signatures on consents and releases. Initially, we had everyone stop at the information desk on their way into the medical center, but departments warmed to the idea of obtaining the signatures themselves.

Managing patients' flow

"Patient response has been wonderful," he continues. "In addition to our outbound preregistration calls to scheduled patients, many call our toll-free number when they are coming to the medical center for services. We give out preregistration wallet cards to all new patients, [encouraging them] to call ahead next time.

"For walk-in patients who bypass the registration areas and report directly to departments," Wren adds, "we have a courtesy phone linked to a preregistration employee for a registration interview. No one walks back to registration. We tube facesheets, consents, wristbands, cards, etc., directly to the clinical department. The departments obtain signatures. After treatment, the department returns the consents to registration and they are scanned into the electronic medical record. We hope to move to electronic tablets to eliminate this step."

In another response to Kehrer's preregistration/consent query, **Marne Bonomo**, PhD, RN, regional director for patient access services at

Aurora Healthcare in Milwaukee, says her department struggles with the same issue.

"Most of our patients across a five-hospital region are either preregistered or go directly to their rooms upon admission," Bonomo writes. "One facility is [more than] 700 beds, so patients are really spread out. While we get all signatures from patients that check in through registration, we find it impossible to search out the preregistered patients on the units.

"Historically, when we did find the patient rooms, the patient was either busy with a clinician or out of the room for a diagnostic or therapeutic procedure," she adds. "The result is multiple missed attempts to secure a signature and uncounted man-hours taken away from registration. This becomes very expensive."

Patient care personnel currently handle this consent signature function, Bonomo notes, but want to hand it back to patient access. A recent survey has shown that many consents are falling through the cracks, she says, "a situation that is not acceptable."

Bonomo says she would love to hear comments and suggestions from *HAM* readers on this subject.

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Promina tries out on-line preregistration

Atlanta-based Promina Health System has rolled out a pilot project for Internet registration for maternity patients, says **Patty Massey**, director of Internet and intranet development. The application is available on the web site of one of the four health care systems that comprise Promina, and "any day" will appear on another system's site, adds Massey. She shared her organization's experience in response to *Hospital Access Management*'s request for feedback from health care organizations exploring Internet registration.

Flyers and cards describing how to access the on-line preregistration option are being given to physician offices, which will distribute the handouts to their patients, she says.

"Promina develops the preregistration application, then interfaces it to each health system's web site," Massey adds. "The patient thinks he or she is in his or her hospital's web site, rather than Promina's." Gwinnett Health System, Southern Regional Health System, and DeKalb Regional Healthcare System are the other Atlanta-area entities that comprise Promina.

"When the patient completes the form, it goes to the individual hospital's registration department," she explains. One of the first steps for Promina's on-line preregistration work group was to standardize the registration form for all four hospitals in the system, Massey notes. "That process took several months of biweekly meetings."

Timely responses

Another emphasis was on how the department would receive the e-mail, who would check for messages and other information, she adds. "It is very important to us that anyone sending information via our web site, especially for preregistration, receive an immediate response and that the information be acted upon in a timely manner."

The registration department receives the on-line preregistrations in e-mail format, she says. "We created a mailbox for a group of registration people, so one person wouldn't be responsible for checking."

If she had the process to do over, Massey points out, she would include Promina's marketing department — which is responsible for each hospital's web site — much earlier in the planning process. As it was, marketing was brought in after almost eight months of planning, when the project was virtually complete, she says.

"Marketing is responsible for all information added to our web site and where it will be placed on the site," Massey notes. "We didn't bring them in soon enough to be able to react when the development was complete. We should have kept them informed — maybe not have them attend each meeting, but keep them in the loop."

The work group targeted maternity services as the easiest area in which to start on-line preregistration, but the focus will expand in the future, she says. "Philosophically, this was a huge step for the health system, although it is a very small part of the hospital's operations. This is our first step in a business-to-consumer approach with our web site."

[Editor's note: Patty Massey can be reached at (770) 956-6080 or via e-mail at massey_patty@promina.org.] ■

NEWS BRIEFS

MA law requires ED interpreters

Massachusetts hospitals are required to provide interpreter services in all emergency departments to non-English-speaking patients, according to a law that became effective July 1.

The Massachusetts Department of Public Health (MDPH) says hospitals must designate a coordinator of interpreter services and notify emergency department (ED) patients of their right to an interpreter and are prohibited from using underage family members as interpreters. MDPH also has developed a Best Practice Guideline for developing interpreter services to assist the state's hospitals.

MDPH commissioner **Howard Koh**, MD, said the new law will ensure that accurate and timely information will be gathered in hospital EDs, where clear communication can mean the difference between life and death. The regulations also require the following:

- posting of notices and signs informing ED patients of their right to interpreter services;
- hospitals to perform an annual language needs assessment in their service areas. ▼

ED visits top 100 million

U.S. emergency departments (ED) recorded 103 million visits in 1999, up 14% from 90 million visits in 1992, according to a report by the Atlanta-based Centers for Disease Control and Prevention.

The number of hospitals providing emergency care did not increase during the 1990s, meaning existing hospitals cared for an additional 35,000 patients each day, the report points out. The report attributes the increase in ED visits to overall population growth and the increase in the number of seniors.

The most common reasons for a visit to the ED were stomach and abdominal pain, chest pain, and fever. About 17% of ED visits in 1999 were deemed emergent, meaning the patient needed to be seen by a doctor within 15 minutes. Another 30% were classified as urgent, meaning the patient should be seen by a doctor within an hour. The report is available at www.cdc.gov/nchs/. ▼

Reorganized HCFA gets new name

The Department of Health and Human Services agency that runs Medicare and Medicaid is no longer the Health Care Financing Administration. In mid-June, it became the Centers for Medicare and Medicaid Services (CMS).

HHS Secretary **Tommy Thompson**, who announced the change at a Washington, DC,

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Editorial Questions

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press conference, also outlined a reorganization of the agency, to be called CMS, with three new centers of service. The Center for Beneficiary Choices will focus on the Medicare+Choice program. The Center for Medicare Management will focus on the traditional fee-for-service program, dealing with providers. The Center for Medicaid and State Operation will focus on such programs as Medicaid, SCHIP, and insurance regulation administered by states. The action was the first in a series of reforms at the agency, Thompson said.

CMS administrator **Tom Scully** announced a $35 million campaign scheduled for this fall to improve education of seniors about their Medicare and Medicaid benefits and choices. ▼

Billing 'out of whack,' focus groups believe

Consumers believe there is gaming going on between the provider and the payer when it comes to billing, and that they are caught in the middle.

Those are among the concerns expressed by participants in focus groups conducted as part of the Patient Friendly Billing Project of the Westchester, IL-based Healthcare Financial Management Association (HFMA) and the American Hospital Association (AHA).

The aim of the project is to help health care providers convey bills — or, more precisely, "a series of financial and other communications" — to patients and their families that are clear, correct, concise, and patient-friendly, says **Richard L. Clarke**, HFMA president and CEO.

The first phase of the project, he adds, will focus on hospitals and health systems but eventually, the focus will broaden to medical practices and payer financial communications.

There is the general sense among consumers, Clarke notes, that the "system" is fundamentally out of whack. "Multiple bills from multiple providers, interacting with one or more payers — all using different forms, terminology, and approaches — creates a system that is almost impossible to track and understand."

While short-term fixes can be made to improve patient financial communications, the main question, he says, is how the system can be changed to get the consumer out of the middle.

"To change the system," Clarke points out, "will require the interaction, cooperation, and agreement of providers, payers, government, and employers — a daunting task."

The Patient-Friendly Billing Project, he adds, recommends a multidisciplined approach that will include these elements:

- a process that captures and summarizes bills from all providers, and automatically matches them with all payments;
- a consolidated communication that clearly identifies all the services that were provided for an episode or episodes of care, the coverage of that care by health or other insurance companies, expected health insurance payments, and what is due from the consumer;
- a single point of contact for the consumer, by telephone or web site, designed to respond to inquiries, complaints, or concerns about benefits, coverage, and payments;
- an appeals process to handle disputes that consumers may have about eligibility, coverage, charges, and payments.

Also under this ideal system, Clarke says, payments by consumers would be made to a single source, and automatically distributed to providers and suppliers involved in the episode of care.

[Editor's note: For more information about the Patient-Friendly Billing Project, call (800) 252-HFMA, ext. 3.] ■