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INSIDE

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State-of-the-art call center at UPMC boosts billing accuracy, collections

Central location simplifies management and training

Developing a new off-site call center for the University of Pittsburgh Medical Center (UPMC) was the mission. The challenge, says **Georgina Trunzo**, director of patient access services for the health system's hospital division, was combining the cultures of six different hospitals and establishing common policies and procedures.

Six weeks after the move — which followed about a year of preparation work — Trunzo says she was seeing a decrease in unbilled reports (cases in which patients are discharged without being final-billed) and a decrease in "dollars out there due to insurance verification not being done."

In addition, she notes, "we're able to trend our denials and identify the root causes — what is done at pre-arrival vs. what is done on site. Having all the employees in one location, we're able to economize on management and do more training."

Having the financial functions in the same building — the pre-arrival call center is located on the same floor as the health system's physician financial services and central payer offices — has enhanced the collaboration between physicians, hospitals, and care management, Trunzo adds.

The central business office for the six hospitals is on the floor below the call center, she notes, which allows daily interaction between the two revenue cycle components.

Going into the project, which UPMC did in conjunction with the consulting firm Cap Gemini Ernst & Young, some initial parameters were set, Trunzo says. "We wanted to centralize pre-arrival function, including pre-registration, insurance confirmation/authorization for outpatients and insurance verification/pre-certification for inpatients. Each facility was doing it differently — some were doing all [the functions], some were doing part. We wanted everybody to do them consistently."

The goal, she said, is to do "100% of financial clearance of scheduled

cases," including inpatient, observation, same-day surgery, and outpatient accounts of more than $500, and to clear within 24 hours the accounts of all unscheduled inpatients.

The six facilities that will be served by the call center include the two largest teaching hospitals, Trunzo notes, and another four hospitals that are on the same computer system — MediPac, by McKesson HBOC in Atlanta.

What the six hospitals also have in common, she adds, is that Trunzo oversees directly the site management of the access departments.

The system's remaining 10 hospitals, Trunzo points out, have been closely involved in the planning that led to the call center's opening. "They helped review procedures and offered insights." The policies and procedures for those hospitals will be identical to those of the call center, she adds, so patients will have the same experience throughout the health system.

The actual move took place between Feb. 18 and March 30, Trunzo says, with employees from the six different hospitals gradually phased into their new quarters in a building off-site from the hospital. The fact that the building was brand new, with pristine employee workstations located near the windows, was a great morale booster, she notes. In this case, she adds, the managers have the interior office space.

Another plus was that for every person who became part of the call center staff, the move was a promotion, Trunzo says, because the job was more challenging. Every employee has to be able to multitask, she says, meaning pre-register, verify, and do financial counseling. She estimates that the cross-training necessary to get everyone comfortable with the duties will take at least 60-90 days after the move.

Individuals who already were doing insurance verification, or in the case of the nurses, clinical pre-certification, at one of the hospitals, were eligible to make the switch to the call center, Trunzo notes. Otherwise, those interested in the new positions had to apply. Pay grades and policies and procedures were established in advance, she adds, which was crucial to the project's success.

"The big thing was to get the human resources departments involved early," Trunzo emphasizes, "to develop job descriptions and pay grades and to help communicate the information to employees."

Each new employee will receive 64 hours of MediPac training, as well as training on the pre-arrival functions and 12 hours of continuing education. Even for those who already know the job, she points out, it's important to ensure that everyone is doing it the same way.

The call center houses 80 full-time equivalents (FTEs) at present, Trunzo adds. "We have built in room for growth — the floor has an extra 60 workstations."

Four lead positions were created, she notes. Also included in the 80 FTEs are 10 nurse FTEs, who do pre-certification and screen for medical necessity and appropriateness of care, and four financial data-quality specialists, who review reports, edits, and denials. "Bills drop three or four days post-service," Trunzo says, "so they review them to make sure mistakes are corrected before [billing]."

The facility's head of training receives daily data-quality reports, which are used to give feedback to staff, Trunzo adds.

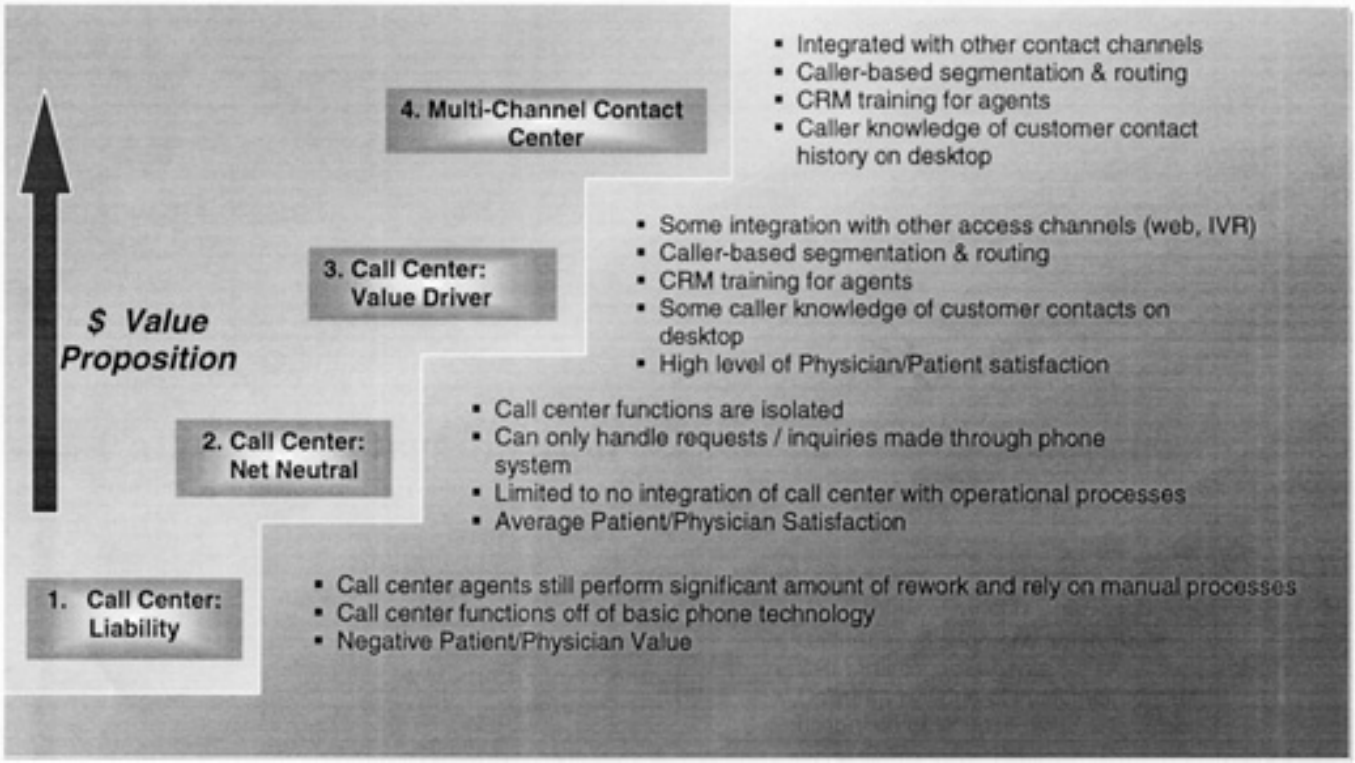
Staff response to the call center "has been wonderful," she reports. "People were scared and had anxiety at first, but we did a lot of communication up front. We didn't have a building to show them at first, but we had an open house and invited them to see the bricks and mortar." Employees recently were invited to bring their children to the new center during "Take Your Child to Work Day," Trunzo adds.

There are plans to build shops, restaurants, and a movie theater in the office complex, as well as a nearby walking trail, she says. That will provide a nice contrast to the previous work setting for many of the staff, Trunzo notes, who were located at UPMC's flagship hospital in a congested downtown area.

'Lots of prep work' done

Before the call center became a physical reality, Trunzo points out, there was "lots of prep work."

Four-Step Call Center Progression



Source: Cap Gemini Ernst & Young.

Working in conjunction with Indianapolis-based Cap Gemini manager **John Woerly**, RHIA, MSA, CHAM, and other Cap Gemini consultants, UPMC did training at the different sites to make sure pre-arrival and financial clearance policies were consistent and that customers were treated the same across the system, she adds.

When it came to the call center technology, says Woerly, UPMC went with some relatively inexpensive systems to help do the work. It can cost between $10,000 and $12,000 per workstation to install a top-of-the-line customer relationship management (CRM) system, he points out. "We didn't go that route here — it was too expensive."

Cap Gemini has devised a four-step progression for a call center, with increasingly complex technology at each higher level, he points out. **(See chart, above.)** "Most people think of either the basic telephone or the other extreme, and they don't see the middle ground.

"It would be wonderful to be at the top of the heap," Woerly adds, "but that may not be affordable. The operation can be just as effective as the third level, which is about where UPMC is," he notes.

"We took the approach of seeing how we could leverage our existing technology," Trunzo says. "Cap Gemini was helpful in providing a technology assessment, looking at what we could do now and what we may look at in the future."

UPMC does not have the CRM technology, she notes, that would allow call center employees to identify patient preferences from past encounters and say, for example, "I see that you like appointments at this time."

That still is the vision for the call center, Trunzo points out, and will be part of the enterprise solutions on which UPMC will work with Kansas City, MO-based Cerner Corp.

With the existing technology, however, supervisors can do "service observing," which means they can listen to telephone calls and voice recordings and give feedback to staff on the length of calls and the call-abandon rate, Trunzo adds. "This lets us know how many calls a person can handle."

Patient access reporting tools developed by Cap Gemini allow UPMC to run reports "to see what work hasn't been done that needs to be,"

she notes. "This includes exception reporting and creates work lists with patient names. We're in the process of rolling out this system." **(See related story, below right.)**

"We've also worked to develop, via our 'infonet,' a benefits engine," Trunzo says. "It is not integrated into MediPac, but allows payer information and contract information for our top 10 payers to easily be viewed. This allows registrars or radiology receptionists to click on and be able to see the payer-specific issues for a patient that wants to schedule, what the copayments are, whether they need authorization, and the numbers to call."

The benefits engine was expected to be in place "within the next few weeks," Trunzo adds.

Meanwhile, a pilot program is under way that allows patients to register on the Internet. The idea, she notes, is that patients who are hard to reach will have another outlet for contacting the call center.

Lessons learned

What she's learned from the call center effort so far, Trunzo says, is that to successfully combine the cultures of six different hospitals, good communication is essential. "We also have to know what's going on not only in our world, but in the other world [of the 10 hospitals that are not included in the call center]," she adds. "You have to engage all stakeholders — you can't do this in a vacuum. I would think I had covered every base and still find one stone unturned."

To streamline the transition for medical staff offices, for example, Trunzo made communicating with the new center as easy as possible. "If they used to send faxes to Point A, we kept the same numbers and had them rerouted to the fax machines. It took a lot of planning and a lot of hard work."

During the transition, Trunzo says, she met with the call center staff every day at 4 p.m. "We identified what they saw, what issues needed to be addressed," she explains. "They had to learn to use new telephones, fax machines, copiers — everything was new. You don't assume everything is basic to everyone."

Because the employees were brought over in phases, Trunzo notes, she had to be conscious of going over the same material with each group of new arrivals.

Response to the call center so far has been wonderful, she says. Trunzo has gotten e-mail thank-you notes from staff. But she says she is very aware that the "real work" now begins. "We are a work in progress," she adds.

[For more information, contact:

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Access tool tracks, sorts accounts that need work

User can 'tailor-make' report

At its new off-site pre-arrival call center, the University of Pittsburgh Medical Center (UPMC) is making use of a patient access-reporting tool, known as PART, created by Cap Gemini Ernst & Young.

"What we are doing is creating an automated method for tracking patient accounts that require and lack benefit authorization, pre-certification, referrals, and notification of admission," explains **Jonathan Bluth**, a Cap Gemini consultant.

There are "hundreds of thousands of rules," he notes, and the likelihood that access personnel might forget one of them. "What we're able to do is establish a list of requirements and any account [that matches one or more of them] will hit the work list. Once it's complete on the ADT [admission/discharge/transfer] system, the account will no longer appear on the work list."

The way PART is being used at UPMC is that a designated team runs a work list for the full staff, he says. "What differentiates this from standard reports is that we are able to adjust the output of the report each time we run it. The user is able to select a whole variety of activity — to sort by patient type, location or service code, and by financial class or insurance plan code."

Outstanding accounts can be segmented according to whether they are Medicare, Medicaid, Blue Cross Blue Shield, etc., Bluth says, and can be split alphabetically by last name, making it easy to divide the work by teams.

"What we've seen is that a lot of other systems have work-list capabilities, but they are either not

flexible or you can't easily change the output," he adds. Some of the hospitals he has worked with have standard reports that include every account that requires verification, Bluth notes. "[Those hospitals] might have the Blue Cross team working off the same 50 pages as the Medicare team."

The advantage with PART, he says, is that "the user printing the report can tailor make it for staff work flow [and] can adjust it in a variety of ways." ■

Nurses and registrars cut barriers to ED patient flow

New discharge process provides closure

Teamwork between clinicians and registrars has streamlined the emergency department (ED) operation at Wake Forest University Baptist Medical Center, in Winston-Salem, NC, resulting in shorter wait times, increased self-pay collection, and a more positive discharge experience for patients, says **Keith Weatherman**, CAM, associate director of patient finance.

What's most impressive about the improvements is that they were accomplished without adding staff, notes Weatherman, who gives much of the credit to **Charlynne Lynch**, manager of ED registration.

When a consulting group identified various barriers to a smooth patient flow in the ED, Lynch says, she focused on "the only thing under my control — registration. My goal was to eliminate any barriers that registration caused."

One of the problems identified, notes Weatherman, was a delay between triage and registration. "Instead of taking the patient straight to [a treatment room], the patient might wait too long in triage for the registration to be completed."

With that in mind, Lynch says, she decentralized the process by putting registrars in the ED treatment areas — including fast track, pediatrics, and adult acute care.

Other enhancements to the ED operation include the practice of having nurses escort patients to the central registration area for discharge, and a new emphasis on collecting on self-pay accounts, while remaining compliant with Emergency Medical Treatment and Active Labor Act regulations.

Before, Lynch notes, patients often were told by clinicians that they could leave, with no real closure to the visit provided. "We would have patients who came back through registration and said, 'What should I do?' Technically, we could have a trauma patient come through and then be able to leave [and have registrars] never even finish getting the demographic information."

Under the new procedure, Weatherman points out, staff are able to update the registration as the patient is being discharged. "By that time, the family may have shown up with insurance information."

The more consistent discharge procedure and increased focus on collections, which began Feb. 4, paid off quickly, he adds. During the month of March, staff identified insurance coverage for $101,000 in charges that otherwise would have been designated "self-pay," Weatherman says.

Cash collections for the months of February, March, and April totaled just more than $75,000, he adds, compared to just $2,000 for the last three months of 2001.

How it works

As always has been the case, emergent patients are directly taken to the treatment area, Lynch says. Under the new process, she adds, other ED patients also are taken to a treatment room if one is available when they are triaged. If the fast-track area is open — and the patient's acuity level is low enough to qualify — the individual will be taken there, she adds. Registrars are positioned in all ED treatment areas to perform the registration at bedside, she notes.

"If a bed is not available, the patient stays in the waiting area," Lynch says. "We have personnel in central registration who will complete the registration." Under the new system, a patient who comes in with ankle pain, for example, might receive an X-ray during the wait, since he or she already is in the system, she adds.

The idea, Lynch says, is that the faster the patient information can be entered into the computer, the faster order entry can begin. "The way the ED is set up, [the patient needs] to be in the computer system for labs to be ordered."

With an acute patient, registrars might do an abbreviated registration, she notes, getting just enough information so that orders can be entered and a face sheet printed before the patient goes back for treatment.

Otherwise, a full registration will be done at

bedside or in the waiting area. Registrars in the treatment areas use radio-frequency laptop computers, which the department already had on hand, she adds, so no capital outlay was required.

One of the problems with the old system, when there were no registrars in the treatment area, is that patients who arrived by ambulance were not being registered quickly enough, Lynch notes.

"We waited for nursing to put the patient's name in the system, which alerted admitting that the patient was here," she says. "This was contingent on the nurse stopping what she was doing to type the name in."

Now that registrars are in the treatment area, Lynch adds, they can see the patient arrive and immediately start the registration.

Nursing plays big role

The support of the ED nurses has been crucial to the initiative's success, Weatherman stresses. "What's impressed me is the folks I've seen who have stepped out of the box and made it a team effort between clinical and registration."

Being escorted to the registration area after treatment conveys a sense of caring to patients, Lynch points out. "They're not just left hanging. The nurse says, 'Follow me,' and takes them to discharge. There's a complete handoff, whether it's by a nurse, nursing assistant, or maybe even a physician."

Once the clinician walks away, she notes, it seems the patient often has a question regarding treatment or follow-up. Personnel at the central registration desk ask if there are any final questions, Lynch adds, and if so, they call and inform the caregivers. "It gives the patient one more opportunity."

Lynch is heavily involved in the faculty meetings of the ED attending physicians and the nursing administration, she says, which has fostered the communication between the areas.

"We have a good working relationship," she notes. "They have given the space for our registrars to be back in the treatment area, and, in return, we gave them a registration booth to enable them to have a third triage area."

Although response to the new process has been overwhelmingly positive, Weatherman notes, there has been "some friction" when consulting physicians find themselves sharing space with registrars.

"It's just a big change," he points out. "Staff are having to learn new roles, they have to walk more, go to the patients. It's been a philosophical change."

All ED registrars received training to familiarize them with the new process, Lynch adds. "We laid the groundwork, told them what our vision was, what the things were that we could control, that we could change."

Teamwork among access staff is a key part of the process, she notes. A registrar in the pediatric area, for example, who may not have a patient to register, must be alert to needs in other areas, she says. Those who are busier, meanwhile, need to "pick up the phone and let somebody know they need help."

Challenges come when all the ED beds are full and everyone is waiting, Lynch adds. "Then we 'flex' back into central registration. [Registrars] have to anticipate and think, 'What do I do in this situation?' It takes a person who can multitask."

Lynch formulated guidelines for what each role in each area would be and a follow-up plan with measurable goals. The monthly goal for registration accuracy, for example, is 96%. The number of consent forms signed compared to patients seen is another measurement, she says.

Patient satisfaction with ED registration, as measured by Press Ganey Associates surveys, jumped 3% following institution of the new ED procedures, Weatherman notes. The hospital did well across the board on the survey, he adds, receiving the No. 1 rating among all facilities using the Press Ganey measurement tool.

To glean feedback from staff, Lynch says, she had each person fill out a survey, and then the supervisors individually met with staff members to discuss their comments. "Some aren't happy, others are delighted," she notes. "A lot of it has settled down in the past few weeks."

Concerns expressed in the staff survey were categorized and will be followed up on, Weatherman adds. "We let [staff] know we want to listen and do whatever we can to correct any problems."

Although she formally has yet to survey the ED nurses, Lynch says she receives positive feedback from them. "I've had nurses stop me and say they really enjoy working with the registration clerks. In one case, a nurse saw a conflict beginning and nipped it in the bud. She stood up for registration."

[For more information, contact:

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Getting the 'right people, in the right environment'

First step in improving admissions process

Renovating, reorganizing space, and "getting the right people working in the right environment with the right equipment," all have been part of improving the admissions process at Philadelphia's Presbyterian Medical Center, says **Anthony M. Bruno**, MPA, MEd, director of patient access and business operations.

The latest phase of Bruno's quest to create a brand-new department of patient access and business operations also has included the hiring of a "bed czar" to streamline the facility's bed management system, he notes. Bruno, who assumed his position in July 2001, is giving *Hospital Access Management* periodic reports as he works to establish the new department.

"When I came here, I found a situation where a year or two ago, the whole access program was taken apart, and physician offices were asked to do the pre-certification [for physician and hospital services] and then send the information to us," Bruno says. "Our evaluation of that was that it wasn't working well; they were all doing it their own way. Twenty different [physician] offices were doing the process very differently, with varying degrees of success."

Before admissions manager **Karen Randall** took the situation in hand, she asked her employees where they saw themselves making the most impact in the department, she explains.

"I sat down with all of them — one on one — and asked them what they like to do and what they do best," Randall adds, "and what they would do if they were in charge."

Sharpening the focus

Focusing on placing the right person in the right job, Randall moved one person from the transfer center, where she had worked with the bed board and bed reservations, to become part of a new group doing pre-certifications and pre-authorization, she says.

The woman, now working at something she considers her strong point, is happy, Randall notes, and the department benefits from the good job she is doing.

That group now performs the pre-certification function for both the hospital and the physician offices, Bruno adds. "[The physician office staffs] have been relieved to no longer be involved. The process was time-consuming and not one they're particularly trained for. It was mostly done by secretaries who have not had the exposure and training that admission personnel have."

When Randall took over responsibility for admissions, she notes, the department was not doing pre-registration. "I always felt that was the best way to go, so I started a program," she adds. "There is someone calling all the patients, verifying information, and telling them about deductibles and how much money to bring in."

Upon arrival, patients simply sign a form and proceed to their destination, Randall adds, reducing wait time from about 15 minutes to between three and four minutes.

Staffing has been increased from nine full-time equivalents to 12, she says, and beginning in June, the department's hours were to be extended to 6 a.m. to midnight, seven days a week. Formerly, the department was open five days a week from 6 a.m. to 8 p.m.

There are plans to resurrect the facility's pre-admission testing program, Randall notes. "I'm meeting with the nurses from the short-procedure unit [SPU] to see if we can schedule those patients in a more orderly fashion."

"We don't really have a formal pre-admission testing program," Bruno adds, "so the short procedure unit was informally bringing in patients [for the testing]. Now we're working with the personnel in the lab and SPU to formalize that and make it more organized."

Several months ago, Bruno says, the hospital formed a bed management committee, made up of himself, the medical director and nurse manager for the emergency department (ED), the chief medical officer, and the chief resident for medicine, as well as representatives from nursing and clinical resource management. Out of that committee's efforts, he adds, came the development of a position called admissions nurse facilitator.

The idea, Bruno explains, was to hire someone with a lot of nursing experience who could take over — and greatly enhance — the responsibilities previously held by an admissions registrar assigned to bed placement.

"In the old process, someone was sitting at a desk in the admissions department doing this," he notes. "Now we have someone who is not only clinically trained, but who is on the spot. [The role] is much more proactive than ever before."

Julie Galen, RN, a nurse who has worked for the hospital for four years, moved from the intensive care unit to become admissions nurse facilitator, says she starts her day by going into the admissions department to find out if any patients are waiting for beds, who on the schedule needs a bed, and to get the names of patients scheduled to come in that day.

After going through the operating room schedule to determine who will need to be admitted after surgery, Galen adds, she checks with the catheterization lab and the ED to see who is scheduled to be admitted after procedures being done there.

"There are some who might be admitted, but [the clinicians] are not sure." Other patients are on a waiting list, she says, including those requesting to be transferred from other facilities. "I take all of the pieces of the puzzle and start to sort."

"After I go to the [bed management] meeting to find out the nurse/patient ratio for the day and to find out what floors are short of nurses, I go to all the floors," Galen says. "I keep a running census and go to the floors on an hourly basis to check discharges."

Before, she notes, the nurse managers would inform admissions staff of discharges at 3 p.m. each after receiving the paperwork. With the new, more proactive process, Galen says, "we don't get one admission on top of another. As a patient leaves, we get another patient. I'm able to see all the floors, and get a good feel for what's happening on each floor. I'm able to tell the staffing clerk if we need extra help, so she can call in another nurse."

"The difference is that [Galen] walks the floors," Bruno says. "She is our eyes and ears." One of the other advantages of having the admissions nurse facilitator, he points out, is that she can work more knowledgeably with physicians and nurses to decide bed placement priorities.

Among other improvements, he adds, the ED staff are much happier. "They have someone who

Carefully crafted appeal letter provides results

(Editor's note: Dan Wassilchalk, director of performance improvement and utilization management at Johns Hopkins Hospital in Baltimore, described how his facility dramatically increased its recovery rate on denied days in the February 2002 issue of Hospital Access Management**.** *In response to a request from readers, he shares below an example of an appeal letter sent by his department.)*

ATTN: Medical Affairs Appeals Department
4 Taft Court
Rockville, MD

RE: [Patient's name]
JHH#
MEMBER ID#
DOS: 12/14-12/17/01

Dear Sir or Madam:

The case of the above patient is being appealed for the denial of 12/16/01. After review of the medical record, it was noted that this 59-year-old with a history of cervical disc disease and multiple surgical interventions, including cervical disc surgery in 1995 and lumbar disc surgery in 1984 and 1994, was admitted after he developed pain in the lower extremity that progressed to the thigh and caused numbness and burning in the foot. Walking, bending, and lifting exacerbated the situation. An MRI was positive for an L4-5 lateral disc on the right and L5-91 disc disease.

An MRI revealed C4-5 and 5-6 effusion and C4 stenosis due to a herniated disc and calcification of his ligament. There also is a small disc at C2-3 and C6-7. He underwent a C3-5 laminectomy with effusion and instrumentation on the 14th. He recovered in the neuro unit and was transferred to the floor on the 15th. On 12/15, his white blood count (WBC) was 8.4. On 12/16, it spiked to 15.9, which required additional observation. Also, on the day in query, he was undergoing physical therapy and receiving education regarding spinal surgery. On 12/17, his WBC had decreased to 11.4 and he was afebrile. It was determined that he was stable for release. Please reconsider the denied day, as this patient could not be released with an elevated WBC.

Enclosed for your review is a copy of the patient's medical records. Please direct your written response to my attention within 45 days of this letter at the above address. Thank you.

Sincerely,

Daniel Wassilchalk, MHA, RRA, Director
Department of Performance Improvement/Utilization Management

goes down and gets a good sense of who's there. That's much more difficult for a nonclinician."

[For more information, contact:
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ACCESS FEEDBACK

Form letter, follow-up attract parents' attention

Gateways Mental Health Hospital in Los Angeles has developed an effective method for obtaining consents from the parents of their young patients, says **Patricia Jackson**, director of patient accounting.

Responding to a request for feedback from **Jean Steinbrecker**, admissions manager at Children's Mercy Hospital in Kansas City, MO, Jackson explained that her facility had experienced the same problems that Steinbrecker outlined: Hospital personnel often struggled with getting the consent signed, particularly when patients bypassed admissions and went straight to the nursing floor.

As Steinbrecker explained, nurses don't think it's their responsibility to get the consent, and parents sometimes don't make it to the admissions department to sign the form.

"To correct the problem," Jackson says, "we have a form letter that is sent out to each parent/guardian who did not complete the consent forms." The form letter reads as follows:

"Your child was a patient at this facility for the period of _____ to _____. However, you did not fill out and sign all of the necessary paperwork. We are unable to bill either the insurance and/or any government agency that might be willing to pay for these services. Please call the business office to make arrangements to come in and complete the paperwork for your child."

If the parent or guardian does not come in when billing is done, he or she is sent a statement for the full cost of care, Jackson adds.

"That has not failed to get their attention," she says. "When they call, upset at the bill, we then re-inform them that signing the paperwork allows us to bill other payers. We also inform them that, ultimately, all services are the responsibility of the patient/parent, and that billing insurance is always done as a help to them."

The procedure has proved effective at her facility, Jackson concludes. ▼

Debate on 'access' vs. 'admitting' goes on

Hospital Access Management readers continue to weigh in on the subject of whether there is a trend away from using the term "access" to describe the department that encompasses admitting and registration functions. **(For a different view, see the guest column, p. 70.)**

Keith Weatherman, CAM, associate director of patient finance at Wake Forest University Baptist Medical Center in Winston Salem, NC, says he never liked the name "patient access," and that the two hospitals where he has worked never made the switch.

"Patients don't usually understand radiology as X-ray or pathology as the lab, so why confuse them more by changing the name from admitting?" adds Weatherman, who says he's been in the registration business for 25 years.

Patient access is more descriptive of the valet parking function, he suggests. "Admitting seems to encompass the many roles that we have, registration being just one of them," Weatherman says. "I vote to go back to the name 'admitting.'"

Although **Grace Fannon**, CHAM, gives her title as "patient access services manager," she says that Clearwater, FL-based Baycare — the health care system for which she works — has changed the departmental name at all campuses back to "admitting."

"The general perception is that no one knew what patient access services was, and even though we formally changed our name, we always answered the phones 'admitting' for our patients," adds Fannon, who works at Mease Hospital Dunedin, one of the facilities in the Baycare system. ■

GUEST COLUMN

NAHAM speaks out on the 'access' debate

[Editor's note: Joe Denney is a veteran access professional, past president of the National Association of Healthcare Access Management (NAHAM) and chairman of NAHAM's communications/publications committee.]

By **Joe Denney**, CHAM
Director, Department of Access and Revenue Cycle Management
The Ohio State University Health System
Columbus

On behalf of NAHAM, I would like to offer some background and additional thoughts relative to the recent flurry of discussion about the name "access" vs. "admitting" or "registration." I vividly recall the many, many hours of debate among the NAHAM leadership and others that took place during several strategic planning sessions/retreats before the issue of changing the name to access was presented to the general membership for a vote. Actually, I was president of the association when the vote was taken, although it was my predecessor Judy Balas, among others, who led the cause in support of changing the name.

I think it is important to be very clear about using the term "access." There was never intent to physically replace admitting/registration with access services. I am not aware of any institution that hangs a sign or waves a banner directing patients to access services. The physical locations of admitting and registration continue to exist and probably always will. And there also never was intent to confuse our patients with the term access services. They will continue to know that place where health care institution employees interview them to collect information and have forms signed as admitting or registration.

The term access services began to take shape in the late 1980s and '90s as the umbrella that encompasses what we in the business are all about. Early discussions included all of the various functions our membership at the time represented. Even back to the time NAHAM was born, members had varying responsibilities. Some were combined admitting and business office managers, some had responsibility for patient information, telephone switchboard, central transportation, etc. Some just dealt with the inpatient piece while others included outpatient registration.

It is important to remember that it also was about this time, in the late 1980s, when a significant portion of our traditional inpatient business began to migrate to the outpatient arena. This, combined with, or actually as an effect of, a significant increase in regulatory requirements, resulted in our membership becoming even more diverse in its responsibilities. Beside the original various functions we performed, new programs managed by the soon-to-be access manager began to pop up all around us.

Centralized scheduling, pre-certification programs, and transfer centers, to name a few, became necessary in many institutions to help manage this new way of delivering health care. Expertise on a variety of subjects, including the Emergency Medical Treatment and Active Labor Act and Medicare Secondary Payer, for example, also became necessary for the successful access manager to understand and employ. In essence, the traditional role of admitting or registration manager has grown by leaps and bounds.

Even more relevant

Although the association name change took place more than 10 years ago, it is the opinion of the current NAHAM leadership that "access" is even more relevant today than it was when the name was changed. Given recent introductions of ambulatory payment classifications, the Health Insurance Portability and Accountability Act, etc., the access manager's role continues to evolve.

Many institutions are developing call centers to accommodate tiered approaches to scheduling in order to optimize customer (physician) satisfaction, but also to ensure that everything possible has taken place on the front end to secure collection of payment on the back end, and actually, to go one step further, to collect those patient copays up front. It just makes sense to encompass all of these functions we perform under the access umbrella.

Finally, I have read all of the comments many have voiced on this subject in the past few issues of *Hospital Access Management*. The opinions are as diverse as are the functions of the folks who shared them.

While not every institution embraces the

concept, the traditional admitting and registration services continue to fit well under the access umbrella. Perhaps it has been the larger or maybe the academic institutions that have stepped up to the access plate more readily or in larger numbers. But I also know of smaller, community-based hospitals and some very large health systems that have accepted and use the access services model.

I represent The Ohio State University Health System, where patient access services have thrived for more 10 years now. The larger department to which I report is called access and revenue cycle management. Access — with all of the services and functions performed under this umbrella — is an integral part of today's revenue cycle management.

And, just as a final tidbit, I notice that a number of *Hospital Access Management* editorial advisory board members represent institutions that have embraced the term "access services." ■

Interpreter service helps care quality, report says

Access to interpreter services — an area that often falls under the purview of access management — improves the quality of care and reduces the likelihood of medication errors, according to a recent survey examining language barriers in health care settings.

The report, released by the Boston-based Access Project, said 27% of those who needed but failed to get an interpreter said they didn't understand the instructions for taking their medications, compared with 2% who either got an interpreter or didn't need one. Among those who reported needing help to pay for their medical care, 54% of those who needed but didn't get an interpreter said staff never asked if they needed financial assistance.

Among respondents who reported having unpaid bills or being in debt to the hospital where they received care, 40% of those who needed an interpreter but did not get one said they would not seek care at the facility in the future because of their debt, compared to 26% who needed and got an interpreter, the report states.

The federal government provides matching funds under Medicaid and the State Children's Health Insurance Program to pay for interpreter services, but only five states exercise that option, the report said. Those states include Hawaii, Maine, Minnesota, Utah, and Washington.

The Access Project is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University.

More information is available at the web site www.accessproject.org. ▼

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Editorial Questions

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CMS to publish changes in regs

The latest changes in Medicare and Medicaid regulations will be published quarterly, under a new plan announced by the Centers for Medicare & Medicaid Services (CMS).

The first edition of the *Quarterly Provider Update* was issued in late April, but subsequent reports will be published on the first business day of each quarter — in January, April, July, and October — according to CMS administrator **Tom Scully**.

Each edition is to include changes from the previous quarter, the actual publication date in the *Federal Register,* the *Federal Register* reference, and a brief summary, as well as all nonregulatory changes that may affect providers.

The report is available on the CMS web site at www.cms.hhs.gov/providerupdate. ▼

ED visits, wait time up 14% since 1997

Hospital emergency department (ED) visits increased 14% between 1997 and 2001, according to new statistics from the Centers for Disease Control and Prevention (CDC).

Last year, there were 108 million visitors to EDs, compared to 95 million in 1997, the CDC report said. Wait time for nonurgent visits increased 33%, from 51 minutes in 1997 to 68 minutes in 2000.

The report points out that because the number of hospitals providing emergency care decreased from 4,005 to 3,934 between 1997 and 2000, the number of annual visits per ED has increased approximately 16% since 1997, from 24,000 to 27,000.

CDC attributes the increase in ED visits to overall population growth and an increasing number of seniors. Those ages 75 and older had the highest rate of ED visits — 65 visits per 100 persons — while the national average was 39 visits per 100 persons.

More information is available at www.cdc.gov/od/oc/media/archives.htm. ■