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Increase upfront collections: It's more important now than ever

But patient balances will get even larger

In today's down economy, increasing upfront collections is even more important for patient access departments, but it's getting harder as many patients are struggling to make ends meet, at the same time that their copays, deductibles, and co-insurances are becoming more expensive.

"Each day, we touch on collections. It seems to have gotten harder in the last three months or so," says **Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Community Health Center in Branson, MO.

Recently, patient access managers at St. Joseph Medical Center in Towson, MD, did an analysis of its self-pay patients and were very surprised at what they learned.

"We were shocked to see that most of our self-pay isn't comprised of straight self-pay patients, but self-pay after insurance," says **Cathy Foster**, the hospital's director of revenue cycle. "It seems like that is growing."

The hospital took its current accounts receivable and broke it down into what was straight self-pay and what was self-pay after insurance. "When we got our results, we had more in our 'self-pay only' bucket than our 'self-pay after insurance' bucket," she says.

When Foster spoke recently at a conference held by the local chapter of the Healthcare Financial Management Association to an audience of mostly hospital CFOs, she shared this information: "I think it was a little bit shocking to them to see that more of our bad debt is coming from balances after insurance than from people coming in uninsured," she says. "I wanted to make them aware of the reality of what the patient accounting and access staff are dealing with."

With more layoffs expected, the number of uninsured is likely to grow, which Foster says will have a "domino effect. It's going to get harder before it gets easier, that is for sure."

A year ago, straight self-pay accounted for 55% of the hospital's out-

standing accounts receivable, with 45% coming from self-pay after insurance. "Now, it's the other way around, and continuing to grow in that direction," says Foster. "Many of the payers we have talked to said that after Jan. 1, most of their copays and deductibles will be on the rise. So we are trying to prepare for that."

Tell patients what they'll owe

Three financial counselors were added to Skaggs Community Health Center's patient access department — for the ED, inpatient, and outpatient areas — along with two benefit and preregistration clerks. Each scheduled procedure is worked up for cost and benefits, to determine how much the patient will owe.

"We then call the patient to preregister and let them know what their out-of-pocket expense will be," says Anderson. "We ask for payment over the phone prior to the patient coming in so they will not have to worry about that on the day of service. If they feel uncomfortable with that, we let them know that it is OK for them to pay when they arrive."

An authorization, face sheet, and cost sheet are attached to the order. When the patient arrives, the registrar collects the money and gets the authorization signature.

"Patients want to know prior to coming in how much their out-of-pocket expense is. And they have a right to know," says Anderson.

Although staff have heard lots of positive comments from patients, there also have been some negative ones, such as "We never had to do this before."

"We provide the staff with scripting for these objections," says Anderson. "The results have been great. We went from collecting $350,000 from one year to $860,000 the next."

Anderson cautions that you should not start collections until you have trained your staff to understand everything there is to know about copayments, deductibles, and contracts. "It is imperative they have this knowledge, so they know what they are talking about when they talk to the patients about this," she says.

She recommends doing role-playing, using key words and providing basic insurance training sessions with all your staff.

Patient access staff at St. Joseph Medical Center were not accustomed to asking the patient for money. Previously, a separate individual handled preregistration, registration, and verification of benefits. "Now those lines are being diluted. We are becoming a preregistration service," says Foster. "The plan is to have the staff go through formal training provided by our self-pay vendor."

Here are four strategies to increase cash collections:

1. Pre-register patients.

At St. Joseph Medical Center, all patient access staff are being trained to preregister patients. Scripts will be used to help patients with copays, looking up benefits, and determining eligibility. We needed to focus on seeing how we can get this money right there at the front end," says Foster. "We are trying to make it as easy for the

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ID patients in need *before* the bill is sent

Patients with insurance often are surprised that they still owe a large balance, says **Cathy Foster**, director of the revenue cycle at St. Joseph Medical Center in Towson, MD.

"We just want to make sure that our patients, whether they are eligible for financial assistance or not, are given every opportunity for us to assist them with paying their hospital bills," she says. "We want to do everything possible to help them out."

Maryland is different from all other states in the way it is reimbursed, because patients cannot be offered a discount. "The only discounts we can allow is 2% if you pay the day of service, and 1% if you pay within 30 days," Foster says. "So the fact that we can't incentivize patients to pay their copays is a little bit of a challenge."

The hospital is doing whatever it can, however, to set up payments for patients or offer them financial assistance if needed. "We want to get the money, but we also want to make it convenient for the patients. We don't want to deter our patients from getting health care because they can't afford it, especially in this economy," Foster says.

Patients may be unprepared

Anna Dapelo-Garcia, director of patient admitting services at Stanford (CA) Hospital & Clinics, says that its patient access department is sensitive to the impact of today's challenging economy on patients and their families.

"Thus, part of providing an excellent patient experience is engaging patients early on about their financial liabilities and managing expectations," she says. "We take great pride in providing options and have dedicated staff to assist staff such as our financial counselors and patient advocacy staff."

At St. Joseph, patients are now informed about options for financial help during the preregistration call. Since half of the hospital's admissions come from the emergency department, these patients are completely unprepared and usually don't know what their inpatient benefits are until they are told. Even scheduled patients may be unaware of their specific benefits for inpatient care, and many rely on the hospital to tell them this information, says Foster.

"We try to give them the opportunity at that point to fill out the financial assistance applications if needed, before they even get a bill," Foster says.

The hospital also is looking at software that will categorize those patients who will never be able to pay, those who can pay, and those who will require financial assistance.

The hospital has a program that automatically gives charity to patients who are homeless or enrolled in any state assistance program, such as pharmacy assistance. "They may not be eligible for our state medical assistance, because you have to be disabled for 12 months or have children. So we have to do what we can while they are still in-house," says Foster. ■

patient as possible."

Only walk-in patients who have never been to the hospital before will need to sit down and register. All other patients will be asked to verify six key data elements when they come in, and within the next year, this process will be done electronically.

Foster says her department has set a goal to preregister 100% of its scheduled patients. "This helps with collections, because it allows us to prepare the patient for their payment or make payment arrangements. We don't want to hold the patient up when they come through our doors," says Foster. "With preregistration, on the day they come in it's very brief. We will also use an electronic signature so that the consent forms aren't lost in 50 different places."

Anna Dapelo-Garcia, director of patient admitting services at Stanford (CA) Hospital & Clinics, says the hospital recently implemented a pre-registration unit, with staff contacting patients prior to hospital services to obtain complete and accurate demographic and insurance data. "In addition, the staff are able to collect a co-insurance or deductible payment during the phone call with the patient," she says.

This new process has improved cash turnaround for the admissions process, says Dapelo-Garcia, and has made for a more seamless patient experience at the time of service. "We were not collecting any payment during the pre-registration call to the patient," she says. "Using a third-party vendor solution to process credit card transactions, we are now able to collect credit card payments over the phone prior to service."

Discussions regarding financial liability begin with the pre-registration phone call. If a patient is unable to pay the expected amount, he or she is referred to a financial counselor for assistance.

2. Allow patients to pay balances at kiosks.

St. Joseph will implement kiosk registration in

spring 2009. "The way we're setting it up is that the patient will be able to swipe their credit card, and the kiosk will tell them what their copay is, based on the benefits that we have already taken care of," says Foster. "We are only going to allow patients who have preregistered to use the kiosk."

Patients can take care of their copay and also their previous balance right on the spot. Foster says that St. Joseph will be the first hospital in the state to use kiosk registration, but that she has gone on site visits and seen it operational in a number of places. "A lot of people are like, 'kiosk? With your Medicare population?' But from the patient's point of view, if they can go to the kiosk and be done in three minutes, many will be all for it. And all patients will be offered assistance. We do not want to take away our personal touch with each patient."

3. Allow patients to pay bills online.

St. Joseph just implemented online bill pay two months ago, but already collections have gone from $10,000 the first month to $50,000 the second month. "And we really haven't done a lot of marketing with that yet. So that is a big improvement," says Foster.

Online bill pay has made a big difference in collections. "It has really contributed to our success," says Foster. "While we are on the preregistration call, if the patient isn't ready to pay the copay then, we give them the amount." Patients can then go online to pay before they come in.

4. Use a price transparency product to give estimates.

St. Joseph Medical Center uses FHS Corp.'s internet solution (www.fhscorp.net) to give an accurate quote for the patient's out-of-pocket costs. "This allows us to do estimates very quickly," Foster says. It takes about a minute for staff to input the necessary information, including the patient's insurance benefits. Based on CPT and ICD-9 codes for procedures and the patient's diagnosis, a letter is printed out with an estimate for what the entire cost will be, and what the patient's portion will be.

Foster notes that Maryland is unique because it is an all-payer state, and hospitals are paid on their charges, not on the DRGs. The hospital worked with the vendor to address this. "They took our hospital historical data, and that's what we base our pricing on. Our rates can change from one day to another, but it's a best-guess estimate," says Foster. "We are piloting that in maternity and it's coming out very accurate. We are very impressed with it." ■

Should you decentralize to increase collections?

Hospital collects almost $700,000

When administrators at Shands at the University of Florida in Gainesville asked his opinion about how they could increase point-of-service (POS) collections, **Tim Carney**, manager of outpatient financial arrangements, told them in no uncertain terms that decentralization was the key.

"I said, 'People are not going to come to a centralized area to give us money. We need to be in the ancillaries, in the lab, in pulmonary, and in radiology.'"

However, decentralizing means adding more staff. Carney asked to double the size of his 25-person department. "I had 25 people in the room calling people and creating accounts and doing it all over the phone, but the problem was we were only collecting $1 million a year in POS," says Carney. Carney asked for a total of 54 FTEs, but his request was denied. Instead, administration asked him where he thought the maximum opportunity was. He told them it was in the magnetic resonance imaging (MRI) area.

"So they gave me six people, and I collected almost $700,000. So then they said, 'OK, it's working,'" says Carney. "Today, I have double the staff, but we went from collecting $1 million to $6.8 million last year in POS."

The only way you are going to collect from a patient is to "be there," says Carney. "If the supermarket let you go out the door with your groceries without paying, would you pay? No — before you leave, you go through collections."

Patient access staff at Shands have made dramatic gains, although they don't always collect the full amount due from every single person. "If the deductible is $200 and the patient says, 'I can't afford that; can I give $100?' You know what? We take it. We're a teaching institution and not hardcore," says Carney. "But we only got that $100 because there was someone there to ask."

If the copay is not collected at that point, then the billing department sends out a bill. "And you can survey billing departments across the nation and see what they're getting, but what I always read is somewhere between 15 and 25 cents on the dollar," says Carney. "So if the copay gets by us, that's all the hospital is going to get."

St. Joseph Medical Center in Towson, MD, currently has a central billing office. "But we do all of the front-end pieces back here. So in order to reduce the cost of an agency to collect their copay, we are training our front-end staff to do whatever they can to get it," says **Cathy Foster**, director of the hospital's revenue cycle.

However, the hospital is now switching to a central registration area where all outpatient ancillary areas will be registered. "Before, patients were registered in the clinical areas, but they didn't want their staff dealing with copays and insurance authorization," Foster says, adding that she expects the new process to decrease precertification denials.

Previously, nuclear medicine and cardiology patients were registered by staff in those areas, but they will now be registered in a centralized area. "This will allow for us to have more standardized procedures," Foster says.

All of the registrars in the centralized area will be trained by an access trainer, the same person who trains all of the hospital's registrars, financial counselors, and schedulers.

"Our trainer's biggest challenge is the insurance piece. The patient may have Aetna insurance, which has an HMO and also a standard indemnity plan. The registrar sees all these cards, and it's very complicated for them to know which insurance pneumonic to pull," says Foster. "Our trainer does very in-depth training with competencies that she puts them through before she lets them go out and do their own thing." The trainer also mentors registrars for their first 90 days of employment.

Two ancillary areas have given staffing resources to patient access, which meant that no additional FTEs were needed. "They had a registrar in their area, but really, they had other things to do," Foster says. "But now they have tightened up some things, and that left them with a resource they can give us."

As compliance becomes increasingly complex, dedicated staff are needed as opposed to clinical staff who also have to worry about patient care, says Foster. "We used to have a single compliance person here, but we are now expanding. With all the minute details that we have to pay attention to now, compliance is becoming a bigger and bigger thing," she says. "You have to scrutinize everything so much."

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Patient access using new Medicare noncoverage form

Patients are given more options

Patient access staff will have to get used to a change for Medicare patients, with the new Advance Beneficiary Notice of Noncoverage (ABN) form now used for all situations where Medicare payment is expected to be denied. The form, implemented by the Centers for Medicaid & Medicare Services (CMS), becomes mandatory March 1, 2009.

The revised ABN replaces the existing ABN-G (Form CMS-R-131G) and ABN-L (Form CMS-R-131L). The form also can be used for voluntary notifications in place of the Notice of Exclusion from Medicare Benefits.

This ABN has a new beneficiary option, under which an individual may choose to receive an item or service and pay for it out of pocket, instead of having a claim submitted to Medicare.

"The form has more options for the patient," says **Vicki Lyons**, patient access manager at Baptist Hospital East in Louisville, KY. Staff tell the patient that compliance has stated that the test will not be covered and ask whether the patient wants Option 1 (they want Medicare billed also), Option 2 (they do not want Medicare billed), or Option 3 (that they do not want the services at all).

"The ABN also now has a phone number for the patient to call if they have any questions, which is nice for the patient," says Lyons.

However, she says that it's often difficult to make the patient understand why Medicare will not pay for a test that they have been told to have by their doctor. "They feel if the doctor has ordered it, than Medicare should pay for it," says Lyons. "So it is challenging to explain this to the patient."

Lyons says that patient access staff are finding that most patients do not want to have the tests if Medicare is not going to pay. "We advise them to call their physicians to make them aware of their decision to not have the procedure," she says.

The only thing that patient access had to do, Lyons says, was to update its compliance software in order to access the new ABN. "Staff were made aware that the form did change somewhat, and that there were more options for them to ask the patient about," she says.

The new form is now included in the hospital's overall training on Medicare Compliance/ABN given to all new hires. "It is part of the many procedures that all the new folks have to learn," says Lyons.

A patient access trainer covers Medicare compliance with the new employees, including review of what tests need compliance. "She also shows them how to enter it into our Medicare compliance software to find out if the order has a covering diagnosis on it," says Lyons. "If the diagnosis does not cover, then we call the physician's office to see if there is another diagnosis that will cover. If there is no covering diagnosis, she will then show them how to print out the ABN for the patient to sign."

First, the trainer shows the staff where to find the list of the Local Medical Review Policies which Medicare requires compliance. "We have this list on our document file on the computer for patient access, so it is very easily accessed," says Lyons.

The trainer prints some patient itineraries out for patients having the tests that need compliance, and the new staff person enters them into the Medicare software. "This way they are getting hands-on training," says Lyons. "If the diagnosis does not comply, then a call is made to the physician's office to obtain additional information."

If patient access staff are having trouble getting a covering diagnosis, they can call coders who work in the hospital's health information management department for assistance. "Since we are not coders, sometimes it can get tricky entering this information and trying to get a covering diagnosis," says Lyons. "The coders have a lot more knowledge on what would be covered and what would not be."

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Invest in patient access team with career ladders

A career ladder has helped the patient access department at Palmetto Health Richland in Columbia, SC, to "build our own leaders," says **Charlene B. Cathcart**, CHAM, director of admissions and registration.

"We like to promote to higher positions from our career ladder graduates. We recently had a Patient Access Rep I promoted into a Financial Counselor position," she says.

All team members start out at the "Patient Access Rep I" level, and can move into the "Patient Access Rep II" level through the career ladder. They are then encouraged to take the Certified Healthcare Access Associate (CHAA) exam through the National Association of Healthcare Access Management. As part of the career ladder, staff are also given tests on registration, billing, and insurance.

The CHAA component was added recently, with two employees taking and passing the test.

"Employees that pass are given a pay increase and are moved up to the next pay grade level," says Cathcart. "Our quality increased from 92% to 97% since implementation. I think that it is an excellent way to invest in your team!"

About three years ago, the patient access department at Children's National Medical Center in Washington, DC, developed a career ladder to improve retention, reports **Fairon F. Fitzhugh**, senior practice operations manager. "We wanted to give our best employees an incentive to stay within our workgroup, and make opportunities available to them for growth and development," she says.

Fitzhugh says that patient access staff are now more interested in learning and more knowledgeable about what it takes to be promoted. "Our retention rates have improved within our workgroup," she says. "Staff are more likely to stay within the institution, even if they decide to leave the outpatient clinical arena."

Fitzhugh says that baseline data were difficult to establish because there was more than one workgroup with the same job titles. "But, I would

estimate that retention rates have improved by 10% to 15%," she says. "Staff in search of growth, development, and promotion are now more likely to transfer to other positions than to leave the hospital's workforce altogether."

To develop the career ladder, these steps were taken:

- Existing job descriptions were reviewed, revised, and updated.
- Tasks were prioritized, so that they reflected increasing job knowledge and accountability. "This process allowed us to see natural 'steps' for our ladder," says Fitzhugh.
- Roles were inserted that were missing from the existing structure.

"Our job descriptions reflect that the knowledge necessary for each step in our ladder builds upon the know-how of the step beneath it," says Fitzhugh. "This makes it easy for our staff to rotate when we're short-staffed."

When using a career ladder, it is important to: establish appropriate levels/steps within the ladder program, determine appropriate salary ranges, evaluate all staff and assignment to a correct level and salary range, identify outliers, and calculate the cost increase, advises **Anna Dapelo-Garcia**, director of patient admitting services at Stanford (CA) Hospital & Clinics.

"Staff quickly adapted to the new process and now feel that there is an opportunity for advancement," says Dapelo-Garcia. "Staff no longer feel it necessary to leave the department in order to advance within the organization."

To get the most out of career ladders in your department, use these tips from patient access professionals:

- **Be sure to clearly define the required steps.**

For example, state clearly that the employee is required to take Registration 201 before he or she can take Billing and Insurance 204, says Cathcart.

"One pitfall is using longevity — years of service — as a primary trigger for advancement to the next level," says Dapelo-Garcia.

- **Have a competency test for each level**.

"Establish your expectation for competition, such as a score of 95% or better passes the class," says Cathcart.

- **Include a cross training component.**

State what additional duties the employee must be able to perform in order to move up the ladder, says Cathcart.

- **Think through the issues that will inevitably come up.**

For example, what would you do if an employee wants to advance but can't pass a competency test? "When employees can't pass a competency test, we give them the opportunity to review the material again and then retake the test," says Cathcart. "If they still can't pass, we have them go through the training again. I don't remember anyone that did not pass the third time."

You also need to decide whether it counts if an employee has worked in the cross training area, but it was several years ago. "My rule about cross training in an area they previously worked in is that all cross training has to be within one year of the career ladder application," says Cathcart.

- **Have a clear vision of what you're trying to accomplish**.

"You need a good understanding of where your current structure falls short of that vision," says Fitzhugh.

- **Think about the type of employees you want to attract, in addition to your existing staff.**

For example, over the last few years, the number of Hispanic patients treated in the hospital has increased, says Fitzhugh. She says that it is helpful to have staff who can greet the families in their own language, interpret basic demographic and insurance questions, and relay information about appointments and directions.

"We are careful about staff translating, however, due to obvious liability concerns. We created a position for a bilingual registrar, which requires the employee to be certified in basic translation through a community college," says Fitzhugh. "This created an opportunity for a few members of our Spanish-speaking staff to be promoted after receiving the requisite training."

- **Get input from human resources (HR)**.

"They may be very helpful when you're ready to implement your new structure, so it's best to include them in the early planning stages," says Fitzhugh. She says that the hospital's HR department was instrumental in the roll-out of the career ladder in clinic operations.

"They were generally supportive to our team in many ways," she says. "They were with us when we met with union representatives about our plans, and helped us draft the informational materials for the staff. HR became another resource to the staff. They were able to field questions and provide our handouts."

- **Create a cross-walk**.

This is a visual reference of positions similar in grade and qualifications across your institution. "This helps staff learn about a variety of job

opportunities available to them within your organization," says Fitzhugh.

• **Be practical**.

"Don't create more steps in the ladder than you need," says Fitzhugh.

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Online pre-registration frees up phone registrars

8% of surgical patients pre-register electronically

Allowing patients the option of pre-registering online is good for patient satisfaction and also frees up patient access staff for those who prefer to speak with a representative.

At all four campuses of California Pacific Medical Center at Sutter Health in San Francisco, surgical patients can pre-register online 24 hours a day, up to one week prior to their procedure. The patient enters his or her demographics, insurance or billing information, primary care physician, and date of service information. Then, the patient sets up a telephone appointment to speak with a nurse facilitator.

"Once they've submitted it, they are sent an automatic e-mail, thanking them for completing step 1 online and reminding them about step 2 — the telephone appointment," says **Janice M. Grey**, interim manager of patient registration services for California and Davies Campuses at California Pacific Medical Center.

Patient access staff process the online pre-registrations twice each day Monday through Friday, in the morning and afternoon. Once this is done, the patient is sent another e-mail to confirm the date and time of his or her telephone appointment. If patients choose not to share their e-mail address, they are contacted by phone.

One benefit is that patients from out of town or out of state can now preregister. "Also, when patients go online to register, they are also

Numbers for online pre-registrations

JUNE

ONLINES PRE REG	CAL ONLINES RCVD	DAVIES ONLINES RCVD	PACIFIC ONLINES RCVD	ST LUKE'S ONLINES RCVD	TOTAL ONLINES	TOTAL PRE-REG
TOTAL	83	26	42	2	**153**	**2,032**
8%						

JULY

ONLINES PRE REG	CAL ONLINES RCVD	DAVIES ONLINES RCVD	PACIFIC ONLINES RCVD	ST LUKE'S ONLINES RCVD	TOTAL ONLINES	TOTAL PRE-REG
TOTAL	99	35	41	4	**179**	**2,222**
9%						

AUGUST

ONLINES PRE REG	CAL ONLINES RCVD	DAVIES ONLINES RCVD	PACIFIC ONLINES RCVD	ST LUKE'S ONLINES RCVD	TOTAL ONLINES	TOTAL PRE-REG
TOTAL	84	26	30	2	**142**	**1,927**
7%						

Source: California Pacific Medical Center, San Francisco.

introduced to valuable health information available to them on their procedure," says Grey.

Training for patient access staff was minimal, says Grey, and covered basic registrar skills for pre-registration, e-mailing, and basic knowledge of the online process.

"Patients are pleased that they have been able to complete part of the process online," says Grey. "I believe it gives them a sense of involvement and control for their own care."

With approximately 8% of these patients pre-registering on-line, phone availability has opened up, so staff can be more available for incoming calls from patients who don't have online access or who prefer to speak with a representative, adds Grey.

"We have the option to have the online preregistrations processed by our clinical receptionist/registrars, who do this function in between scheduled patients when they have down time. This gives even more availability to have registrars available for patients calling in," says Grey.

Online preregistration also is offered to maternity patients. "Because of the demographic age of this patient type, 55%-60% of the 600 patients we service each month register online," says Grey. **(See chart showing the actual numbers of online registrations for three months in 2008, pg. 140.)**

Patient access staff really did not have much difficulty implementing this new process, which saves them time just as it does for patients, says Grey. "Getting the information out to our patients that this process was available was one little glitch," she says.

This was handled with informational flyers on the new service, and on how to access the hospital's web site. These were given to all physicians using the surgery department. Patient access managers also had luncheon meetings with the physicians' office staff, letting them know this was an additional way for their patients to pre-register.

"The online system is actually easier for the staff," says Grey. "They are basically just doing data entry, instead of face-to-face interviews with the patients or spending time trying to contact them by phone to do the registration."

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Electronic ordering halts misplaced, missing orders

No more unnecessary rework

After an electronic ordering process was implemented at Bon Secours Hampton Roads Health System in Marriottsville, MD, the central scheduling department stopped "pulling their hair out" looking for misplaced or inaccurate orders.

The department takes very seriously its goal of providing excellent customer service 100% of the time, says **Dee Sutton**, manager of central scheduling. Previously, central scheduling received about 250 to 300 hard copy faxed documents every day. Staff would take each document to the assigned scheduler's desk to verify it for accuracy, where the scheduler would either enter a code indicating a stamp of approval or follow up if there was an error.

Then, each document was batched by facility and/or department for five facilities and manually faxed to the appropriate area. The document was then filed in large crates by facility, month, and date.

"We kept all hard-copy orders on file for 90 days. If an order was misplaced, central scheduling had to go through the many papers trying to find it, and then fax it again to the necessary area," says Sutton.

This was easier said than done, due to appointments being rescheduled several times, requiring a lot of research to locate each document. "Not only was it extremely time-consuming, but it often caused unnecessary rework," says Sutton. "This led me to look for a solution. My team was pulling their hair out."

The problem was so common that the team even created a "next day missing order" document that each facility's admitting office would fax to central scheduling each afternoon around 4:00 pm. "This helped us begin searching for orders that had been misplaced before we closed at 6:00 pm," says Sutton. "Usually, missing orders were due to patients' rescheduling or not showing for their exams."

Sutton set out to improve all-around physician, patient, and employee satisfaction. She also wanted a method that would give the necessary staff members the ability to view and/or print the document at the press of a button.

Staff go live with new process

"Our goal is to ensure a physician's order is on file for every outpatient ancillary exam scheduled," says Sutton. "The only exception is an annual routine screening mammogram, which does not require a physician's order for the patient to receive services."

To address this, the department implemented QuadraMed's Inbound Fax Viewer solution. This is the new process:

Central scheduling staff members begin their call by introducing themselves and reviewing the basic patient demographic information.

A window appears, reminding the scheduler to ask if the patient is to bring the physician's order or if it will be faxed to the central scheduling department.

The scheduler then notes the caller's reply in the proper fields on the questionnaire.

If the ordering physician's office has chosen to fax the patient's order to central scheduling, the following process takes place:

The physician's order/document is received in the fax server and is automatically assigned a file name/number.

The document is then viewed in the inbound fax viewer.

If a document requires rotation or extraction, this process is handled in the inbound fax viewer.

After ensuring the document has been positioned correctly or extracted to become a standalone document, it is viewed for accuracy.

To ensure the appointment has been scheduled correctly, the order is compared to the scheduled study in the system.

"There are six subjects we carefully view to ensure accuracy," says Sutton. These are the patient's name, the ordering physician's name, the ordering exam, the facility where the exam has been scheduled, the appointment date and time, and any additional notes, such as ICD-9 codes, that may be on the order but not shared at the time of scheduling

Once the scheduling staff member confirms the scheduled appointment is 100% accurate, he or she enters a code indicating approval. The document is renamed in the fax server under the patient's last name, then first name. The document is then attached to the scheduled appointment in the system. Lastly, the document is electronically filed in the appropriate scheduled facility/month folder.

Better satisfaction all around

"The ability to electronically receive, attach, and store documents has benefited our organization while improving physician, patient, and employee satisfaction," says Sutton.

All users have the ability to view and print documents from any workstation. "It has also reduced supply cost considerably by decreasing the need to print documents, which in turn decreased the need for other office supplies," says Sutton.

Physician and patient satisfaction has improved, due to the substantial reduction of lost and missing orders.

By attaching the physician's order to the scheduled exam in the QuadraMed system upon receipt, the order is always available. Rarely is a physician contacted because an order cannot be found.

Central scheduling verifies the scheduled appointment with the physician's orders to ensure it is 100% accurate, and follows up if it is not.

"If there is a discrepancy, our goal is to have it resolved before the patient's arrival," says Sutton. Employee satisfaction has improved due to all users within the organization, including revenue cycle, having the ability to search for a document within the application without leaving their workstation or contacting another department for a copy.

"There were very few challenges when implementing this electronic ordering process," says Sutton. "Our biggest challenge was in deciding how to set up the Biscom fax server to meet our

needs."

Once that decision was made, the necessary fax line was added and testing began. "Thanks to our dedicated department staff members, the program was tested, employees trained and 'go live' was virtually seamless," says Sutton.

[For more information, contact:
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Patient access attacks ED problem 'on many fronts'

You can't control root causes, but you can have impact

If your hospital is like most, patients admitted through the emergency department are being held, possibly in hallways, for hours and even days. It's a complicated problem that the patient access department isn't responsible for and can't control. Still, you bear the brunt of the poor customer service scores that result from this situation.

"Patients waiting for an inpatient bed perceive this wait to be part of the admission wait time," explains **Pam Carlisle**, corporate director of patient access services at OhioHealth in Dublin.

"Not only are patient access staff rated on this issue by patients, which is out of their control, but they are also held accountable for this score on their customer service scorecards," she adds.

In contrast to bedside registration, which ensures privacy and confidentiality, the patient's privacy is potentially compromised by being interviewed in the hallway, says Carlisle. "Patients may rate the customer service of patient access staff lower because the patient's overall treatment time in the ED did not meet their expectation," she says. "Either they waited too long to see the physician or they waited too long for a bed on the floor."

As with most hospitals today, Ohio Health is forced to hold patients in its ED who are being admitted and waiting for inpatient beds to open. The issue, says Carlisle, is a result of numerous patient throughput issues — not just a shortage of staffed inpatient beds.

For example, patients scheduled for discharge may be waiting for family to arrive to pick them up, or nursing units may plan to discharge patients but are kept waiting for several hours for the discharge order to be written.

"We believe that although we do not control the elements, we can have an impact around the outcomes," says Carlisle. "At this time, we are attacking the problem on many fronts."

Here are some things that have been done:

• Patient access has worked with clinical staff to make the inpatient units more aware of the time delays.

"We have set into place some process steps to make each unit more accountable for those delays," says Carlisle. "We are hoping that this will decrease the wait time to be admitted."

Registration staff help round with the ED patients during long wait times.

"This keeps the patients informed of what's going on, and also helps with customer service scores," says Carlisle.

• Volunteers visit with all ED patients experiencing an excessive wait for a bed.

The volunteers keep the patient and families informed of where and when a bed is expected to open. They also provide food, drinks, and blankets.

• Patient access enlisted the help of the hospital's process excellence team to work on a project related to patient throughput.

"This project involves all patients and is not just looking at ED patients," notes Carlisle.

• Some low-acuity patients who require only basic treatment are seen by the physician in the triage area and are discharged from triage without ever being registered.

"These new 'fast track' patients require patient access to redesign their process to accommodate the patient flow improvement," says Carlisle. "It is a good design for the patients, so we have to

COMING IN FUTURE MONTHS

- Proven approaches to improve registration accuracy
- Limit the damage that can be done by bad data
- Dramatically reduce precertification denials
- Strategies to cut time out of the registration process

find a way to make it work!"

• **A goal was set to discharge patients by noon each day.**

"Most discharges are known early enough to get the patient out by noon," says Carlisle.

Major changes free up beds

"Crowding has increased our wait times for lower acuity patients," reports **Patricia Kunz Howard**, PhD, RN, CEN, operations manager of emergency and trauma services at University of Kentucky Chandler Medical Center in Lexington.

"Boarding does impact access and increase waiting times, as well as ED length of stay," says Howard. "Our facility has been very proactive. We have implemented many changes to address crowding and patient access."

The hospital's "capacity management" staff use electronic bed boards to track available beds, and patient transfer facilitators were added to ensure timely access for patients. Patients who need observation can be moved to the clinical decision unit to free up ED treatment space.

The hospital also utilizes a "Full Capacity Protocol," which converts pre-determined private rooms into semi-private rooms, to move patients out of the ED.

"When we are experiencing crowding, we utilize a pre-divert meeting with the capacity management staff, the hospital operations administrator, and the ED charge nurse to try and push some patients out of the ED," says Howard.

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