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Is your hospital shortchanging its front end? Show them these figures

It's the 'perfect time' to obtain resources

Even though patient access has a major impact on the hospital financially, the department often is still shortchanged. This is especially true now, with hospitals looking to cut costs anywhere they can, implementing hiring freezes, and asking departments to do more with less.

Peter Kraus, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta, says that one facility's access department had to let seven staff members go, with the director taking a 10% pay cut, along with other directors in the organization.

"Whether hospitals will lose money in the long run by taking such measures is not necessarily easy to quantify. In principle, the answer is yes," says Kraus. "But it depends on what access has been doing up to that point to contribute to the bottom line."

Also, if an organization's budget is squeezed by current economic circumstances, notes Kraus, it may be forced to cut back on present expenditures — regardless of how those cutbacks compromise future financial performance.

EXECUTIVE SUMMARY

This is a special issue of *Hospital Access Management* on the challenges faced by patient access during a difficult economy. Our cover story reports on how to make higher-ups aware of the financial impact of patient access. Feature stories cover how to increase your salary, how to turn a down economy into an opportunity, how to increase upfront collections, and ways to improve registration accuracy.

"That said, one would hope that, even in hard times, an access department with an aggressive, proven record for enhancing the revenue cycle will always be in a more favorable position than one that is viewed as simply clerical collectors of data — if any still are these days," says Kraus.

Depending on what happens in the financial world, and at your facility in particular, cutbacks may be unavoidable. "In that case, the fate of aggressive upfront programs may rest on their past record," says Kraus. "If there is no quantifiable past record, the facility will have no way to verify that a valuable program is being put at risk."

If you believe your front end is being shortchanged, there's no time like the present to make higher-ups aware of what an investment in the upfront revenue cycle could do to the hospital's bottom line.

"I think the industry, as a whole, is more aware of the criticality of access functions than it has been in the past," says Kraus. "But it never hurts to remind the powers that be."

Time is right for action

Here are some actions you can take:

• Create reports and other measures, not only to gauge how your department is doing, but with an eye on demonstrating the program's impact to the bottom line.

"This can be a lot more than merely collecting copays and deductibles," says Kraus.

For example, obtaining upfront insurance verification and pre-certification can save many dollars in denied claims. You can demonstrate this with before-and-after statistics.

"Getting insurance data right upfront the first time, or at least before the account is billed, can reduce both the number of rebills and the number of days it takes to collect the account," says Kraus.

• Be prepared to work with fewer resources.

Whether or not you succeed in "doing more with less" may depend on your department's current staffing levels. "If they are minimal, something is likely to give," says Kraus.

However, if your department has been maintaining reports and records of its financial impact, you are in an excellent position to quantify your effect on the bottom line.

This information can be particularly useful if your resources are being cut. "What so often is asked is not to abandon a program but to maintain it — if not expand it — with fewer resources," says Kraus.

To manage resources in a shrinking department, Kraus suggests focusing well trained staff, possibly supervisors, in rigorous post-registration quality assurance and follow-up. "You want account information to be as complete as possible and 'claim-ready' in the interim between discharge and final billing," he says.

• Attempt to get better deals from vendors.

Kraus says that this also is a good time to "lean" on outside vendors to provide additional services, or services at more favorable rates.

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"They are doubtless aware of the facility's tightening circumstances, and don't want to lose the business," says Kraus.

A simple example might be asking a vendor who verifies insurance coverage and benefits online to expand the service to include demographics verification and eligibility for assistance or charity write-off.

• **Look for ways to collaborate.**

"Access should position itself as a collaborator, not a resistor," says Kraus. "It should be proactive in finding ways to work more efficiently, not waiting for draconian measures to come down from on high."

For example, vendors with insurance verification products may be working with other departments at your hospital, which might give you more leverage with rates. "Working collaboratively makes sense, in good times or bad. It can become a necessity to cope effectively with cutbacks," says Kraus.

You'll also want to work with the business office to be sure that account information is "claim-ready." "It is in everyone's best interest to send out a clean bill the first time," says Kraus.

Invest in front end

Beth Keith, CHAM, manager of ACS Healthcare Solutions, says that the best performing organizations spend more dollars per claim in patient access rather than in billing and collection, and also, spend less overall per claim to collect.

"This should be a perfect time to present to administrators the benefits of front-end preparation to reduce the overall cost of collection," says Keith. "This is a metric that is widely used to measure performance in the collection arena."

Most of the software necessary is priced in the mid to low range, says Keith, so the return on investment is typically seen in less than two years.

"There are many good articles and documented success stories related to the increase in collection by adding the right software and effort up front," says Keith.

She says that the major collection companies will tell you that your chance for collection is 95% if done in advance and 75% if done at the time of service — but once the individual leaves the premises, the collection success rate drops to about 10%.

For this reason, investing resources on the front end is a good idea. "The most significant return on investment is produced by maximizing IT resource dollars at that point in the revenue cycle process," says Keith.

The reason is that patient data provided are accurate — including address, insurance, medical necessity, and overall coverage options. "Copays can be accurately estimated and collected at the time of entry into the system," says Keith. "The activity of billing and collecting will flow just as it is supposed to, without human intervention."

If each of these steps is performed correctly, little beyond posting the payment has to be done on the back end in the traditional billing and collection process. "And typically that can be done electronically as well," says Keith. ■

A bigger salary in *this* economy?

It just might be possible

Fair or not, patient access managers have historically had lower salaries than patient account managers. But this is something that just might be ripe for change — even in today's down economy.

To command a higher salary, you need to show administration the true impact your department has on the bottom line. "I have no problem arguing that access management and staff should make more than patient accounts, if they do the sort of job they should be doing," says **Peter Kraus**, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta.

First, you must be able to show that patient access has as big an impact on collections as patient accounts does. "Also, you need to show that access is responsible for all the other non-revenue-generating functions that patient accounts doesn't have to concern itself with," says Kraus.

Here are other steps Kraus recommends patient access professionals take to increase salaries:

• **Obtain additional certifications**.

In addition to obtaining the Certified Healthcare Access Manager (CHAM) certification

offered by the National Association of Healthcare Access Management (NAHAM), you should seek certifications in patient accounts as well.

These include: Certified Patient Account Manager (CPAM) offered by the Association of Healthcare Administrative Management (AAHAM), and Certified Patient Account Representative (CPAR) and Certified Healthcare Financial Professional (CHFP), both offered by the Healthcare Financial Management Association (HFMA).

"I don't have any hard figures, but from my long-time association with NAHAM I know that many facilities either require or prefer access directors/managers to be CHAMs," he says. "If they expect their patient accounts managers and directors to be certified through HFMA or AAHAM, it isn't hard to intuit the enhanced capabilities of an access manager certified in both areas," says Kraus.

Kraus acknowledges, however, that no matter how many certifications you possess, there are no guarantees. "Very capable people sometimes lose their jobs in a depressed economy, and being credentialed doesn't automatically make you capable," he says. "Even so, it can't hurt. And it may help, even if only to find a new job."

• **Pursue an expanded revenue cycle role.**

To do this effectively, you must first understand what new opportunities are out there. Kraus notes that NAHAM has focused on revenue cycle issues for many years, so joining that organization is an important first step, along with HFMA. To get up to speed on opportunities in access, Kraus recommends reading articles pertaining to up-front revenue cycle activity.

• **Work collaboratively with your patient accounts counterparts to promote recognition of common goals**.

Kraus advises working with medical records, utilization review, social services, and vendors specializing in qualifying patients for medical assistance. Your goals: to target long-stay accounts with potential financial problems or simply to identify uncollectible accounts early in the cycle so they can be written off promptly and not adversely impact A/R.

"The them-against-us mentality is a ticket to nowhere," says Kraus. "Every facility is different in terms of gaining influence, but revenue matters weigh heavily on CFO and other administrators' minds. Gaining familiarity with and demonstrating willingness to participate in up-front initiatives is bound to get access noticed." ■

With collections, all eyes are on patient access

There is more pressure—but also more opportunities

Patient access professionals report being under intense pressure to help the hospital's bottom line.

There is "absolutely more pressure on patient access," according to **Jamie Biegler**, director of patient access at Shands Healthcare in Gainesville, FL. "We are under a lot of scrutiny right now. Our precert denials and cash collections are the focus of a lot of meetings."

On the other hand, the bad economy means that patient access, in some cases, is finally getting the attention and resources it needs to reduce claims denials and increase collections.

"We are taking this time to put better processes in place, and upper management is willing to give us the resources we need to get it done," reports Biegler.

Cathy Foster, director of revenue cycle at St. Joseph Medical Center in Towson, MD, says she thinks the bad economy is "absolutely an opportunity for patient access. While hospitals are probably looking at reducing some of their resources, I think they have to look at the value that one patient account brings to the table."

Show the payoff

In order to obtain additional staffing resources in these tough times, you'll need to demonstrate to upper management that more FTEs will result in significant increases in collections. Foster says it's clear that if more attention to detail can be given to every account, "they will see the payoff very shortly."

Foster notes that the average registrar's salary is about $25,000. "You have many patient accounts that are way over $25,000. You can pay a salary with one patient account, if the account is registered correctly, with the benefits verified, and the patient's portion collected."

However, Foster says she thinks it's still a struggle for patient access managers to emphasize the importance of the registrar's role in reimbursement. "That is a still a challenge.

"I still hear us considered as 'overhead,'" she says. "It's true that we don't generate revenue by giving patient care, but we do by assuring that

we are getting paid for whatever the patient is coming here for."

Foster notes that employees in clinical areas often will say that it's not their job to make sure the patient's insurance is good. "But on the other end of that, if they are scheduling patients themselves, what is the use of having volumes of patients if we are not going to get reimbursed?" says Foster.

Share these indicators

Katie M. Davis, director of patient financial services at Carolinas Medical Center in Charlotte, NC, agrees that the challenging economy provides an opportunity "to show the value of patient access to the organization."

She recommends compiling statistics on collections, denials, and patient satisfaction. "Do monthly reports showing the impact of up-front collections, as well as other key performance indicators that show value to the organization," says Davis.

Davis uses a matrix that shows cash collections, both month to date and year to date. The matrix also lists performance indicators specific to pre-registration — the percentage of accounts pre-registered for the next day and for four days out, and the percentage of pre-registered accounts that are completed for the next day and for four days out.

"Our definition of 'completed' is the account is pre-registered, insurance has been verified, the non-clinical authorization has been obtained, and the up-front cash call has been made to the patient," says Davis.

Davis shares this matrix with her vice president at their weekly standing meetings, and in turn, he shares them with the senior vice president at monthly meetings. "I have used the information for both obtaining additional resources and to spotlight the work we do," she says.

According to **Peter Kraus**, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta, "Access should know how much it collects up front each month. If the department trends its collections, that can be helpful."

Upfront collection of elective self-pay accounts is an essential part of access' responsibility, notes Kraus. "However, while I have nothing against upfront collections of copays and deductibles, this is bound to be only a small fraction of a facility's total cash collections," he says. "I admit that sometimes it puzzles me that so much emphasis is placed on copays and deductibles."

Two arguments, however, argue in its favor, says Kraus: First, copays and deductibles are getting higher in today's environment of reduced benefits. Also, vendor verification software is available to provide a more accurate estimate of patient-owed amounts than was once the case.

"Even so, in terms of percentages of total collections, it isn't difficult to see why a budget-constricted CFO might be willing to sacrifice access FTEs in preference to the business office," says Kraus.

But there's more to the story than that, says Kraus: Access departments with robust, proactive pre-registration programs catch patients with potential financial problems before services are rendered and expenses incurred.

"I don't know whether access departments typically track these patients. But a savvy access manager or director should ensure that the powers that be are aware of the role pre-registration plays in identifying and following up with patients at financial risk," says Kraus. ■

Upfront collections are 'a must' for survival

Increasing upfront collections has always been a top priority for patient access departments, but in today's economy, it's "a must," says **Cathy Foster**, director of revenue cycle at St. Joseph Medical Center in Towson, MD. "We have to do that to survive."

At press time, Foster says that her department has not set its targets yet. "But we will be focused on getting at least $75,000 to $100,000 per month," she says. "This may not sound like much, but it will receive a lot of attention now because of the economy. Now all of the clinical areas want to know their worth to the facility. They are also open to the collection processes, especially now that we have centralized registration."

Foster notes that if you are not getting anything at the point of service, many hospitals wait until get they get paid from insurance before they bill the patient. "So that's increasing the number of days in A/R. At least if you are getting something at the front end, it's not as hard of a hit on the A/R."

At Shands Healthcare in Gainesville, FL, the

patient access department has a $7 million a year goal to meet for cash collections. This includes the ED and outpatient and inpatient areas.

"This amount is adjusted annually after consideration of our financial climate and our ability to meet the previous year's goal," says **Jamie Biegler**, director of patient access. "Our administration has been very supportive in providing the necessary tools and staff to achieve the goal."

Here are some strategies that various patient access departments are trying to increase their upfront collections:

• Patients are given the opportunity to use kiosk registration.

Foster says she has high hopes to increase her department's upfront collections with a kiosk registration program her department is implementing this spring. She says this is particularly important for her department, as the Maryland Health Services Cost Review Commission does not allow for discounting more than 2% for day-of-service payments or 1% within 30 days after discharge. "So given the fact we cannot discount to increase payment at the time of service, we will hope to increase collections significantly — because now we do not even ask in most cases," she says. "I expect collections to increase up to 50% more than we receive now."

The kiosk will allow patients to swipe their credit card. At that point, they can determine if they can pay their entire copay, and also, it will bring up previous balances so patients can pay these as well.

• Transfer patients are now financially cleared before arrival.

The economy has changed the "take all comers" practice for patient transfers at Shands, according to Biegler.

"We are a state-of-the-art teaching hospital and a lot of people want to come here," says Biegler. "Before, we would try to get the insurers to verify after the patient got here. The physicians kind of had an 'open door policy,' and we were able to get most of it authorized after the fact. But as the economy took a turn for the worse, things got real tight."

Where in the past transfers were usually a "done deal," insurers are increasingly denying authorization for these, says Biegler. "So that was a new challenge for us."

In light of this, a new process was implemented with patients financially cleared before, instead of after, they arrive. "We now get the transfer and the procedure authorized before the patient comes in the door. There has to be an identified payer source," says Biegler. "Physicians like it, because they don't have to get involved in the clinical aspect of it until they know the patient is going to come."

The only exceptions to the policy are neurological cases, pediatric cases (because it's usually possible to get a payer source such as Medicaid identified), and burn cases, since Shands is one of the few facilities in the region with a trauma unit. "Authorization is not usually a problem with these particular cases," says Biegler. "But for the other ones, the policy is followed strictly. The administrators know it, the doctors know it, and we saved ourselves tons of money in the process."

Occasionally, doctors will want to bypass the policy and have their patient transferred to Shands regardless of payer source, but this has to be approved by administration first. "We do a workup financially and let them know what they are looking at. If they choose to approve it from that point on, then so be it. But more and more these days, they are declining because of the impact to the bottom line," says Biegler.

One problem was that physicians were worried about maintaining good relationships with their referral sources. To avoid problems with these relationships, patient access "gets between" the doctor and the referral source to explain that although the doctor has clinically accepted the patient, patient access can't financially clear him or her.

Some insurers even allow the patient to see the physician several times — but when the patient needs surgery, they won't pay unless the patient has the surgery at another facility. "We try to bargain with the insurance companies, but they haven't budged on a lot of these cases," says Biegler. "We see that becoming a lot tighter."

• ED copays are collected aggressively.

Self-pay patients have increased dramatically at Shands' ED. "We find ourselves being, more and more, an urgent care center. There is not much you can do there, except to have an onsite vendor for Medicaid," says Biegler. "We do screening on the spot and try to get them some sort of assistance. And we are aggressive about collecting copays."

After the patient receives a medical screening examination as required under the Emergency Medical Treatment and Labor Act, insurance is verified and copays are collected at that time.

• Almost all patients are pre-registered.

Foster says a patient recently called her

because she was worried about getting hit with an unexpected bill at the hospital. "She told me that she recently had surgery at another hospital and was called into the financial counseling office there and had to pay $900 that day, without any preparation," says Foster. "We don't want to do that to the patient. That is why we want to have 100% of our scheduled patients preregister. We have the interview with them at that point."

At Carolinas Medical Center in Charlotte, NC, patient access works with a company that makes outgoing calls to surgery patients to inform them they are not pre-registered for their upcoming visit. The call gives them the choice of receiving instructions for pre-registering over the web, speaking to an access representative, or leaving a message for a time that is more convenient for staff to call back.

"This has allowed us to pre-register further in advance without adding staff," says **Katie M. Davis**, director of patient financial services.

• Staff are being trained to set up payment plans.

Patient access staff at. St. Joseph are being trained to set up payment plans for patients who can't pay their entire copays at the time of registration.

"Our goal is to have every access staff member trained to set up a payment plan and collect whatever the patient can pay that day. Even if they say, 'Well, I can pay a quarter of it,' that is better than not paying any of it," says Foster. "It hasn't been in our culture to do that."

Many hospitals fear that their volumes will go down because in this economy people are putting off elective procedures. "Unless we make it easy for them to pay, our volumes will decrease," says Foster. "And we also realize that getting something is better than getting nothing."

At St. Joseph's registrars go by a corporate policy and procedure to determine the minimum amount they can accept from a patient. "If it's a large amount, we can give them a longer period of time to pay, vs. a $25 copay that we would probably want within two months," says Foster.

Foster says she has heard that another hospital is considering implementing a new policy: If a patient has a copay over a certain amount and can't pay it at the time of service, they will suggest that the patient put off the service until they can.

"That's a philosophy that the hospital as a whole would have to decide on," says Foster. "I personally feel that if the patient is insured, at least you are getting that payment for the procedure. But the decision we can make in patient access is that we can discuss payment arrangements with everybody, no matter what the amount is. We don't want to put off people getting elective procedures if they are insured and have a copay."

At Shands, patient access staff have noticed an increasing number of patients can pay only a portion of their copays or deductibles. "We are seeing more and more of that these days, where patients will say, 'I've got $150 but I can't pay it all,'" says Biegler.

For this reason, a new web-based system was implemented so patients can easily make payment arrangements, such as paying $50 a month. "Our staff can actually put in a set amount for the patient to pay each month on their check routing number or credit card, so it can come out automatically," says **Elizabeth Faulk Brooks**, assistant manager of outpatient financial arrangements at Shands.

• Patient access has tightened up processes for intake.

Biegler sits on a committee on payer mix liability, commissioned by upper management with the goal of saving money on self-pay dollars. "Administrators are keenly aware of the increase in self-pay dollars," she says. "We are looking at this across the board at our facilities."

Biegler says that recently a decision was made for patient access to "tighten up" some of its processes for intake and identifying payer sources. "If we are giving a lot of self-pay dollars to folks out of state, we aren't able to take care of our own," she says. "Whereas before we would take a patient in, no questions asked, that's no longer an assumption. They now have to be cleared by upper management."

• Patients are given more accurate estimates about what they'll owe.

"A lot of people do want to pay their bill upfront, and they want to know what they are going to owe," says Biegler. "If you get it upfront, you are in much better shape than if you wait until the end and the patient doesn't have it any more."

To give patients better estimates, Shands has developed a new estimate system, which will be implemented by mid-2009. In the past, patient access staff took the last five cases, looked at the high and low amounts, came up with a rough estimate for a procedure, and collected on that amount, which may not have been accurate. "We will be using a new system developed by IS that should be spot on," says Biegler. "It will give

self-pay estimates as well as deductibles owed."

• A new process is used to reduce claims denials for radiology.

At Shands, patient access is completely decentralized, with 58 FTEs in outpatient areas, all located where services are performed. "We create the account, get all the authorizations, do the precertifications, contact the patients, and collect at point of service," says Brooks.

This means having to work with every single ancillary department — each with different processes. "Each ancillary has its own scheduling system that we have to pull from. So that is a barrier as well," says Brooks. "The processes are not similar and nothing is streamlined. Our schedules are multifaceted — they are web-based, pulled from the physician group's system, or they're paper. Each of our employees has to have multiple sign-ons and be educated on each system."

Recently, patient access noticed "huge percert denials" involving radiology. When the X-ray is ordered, such as a computerized tomography (CT) scan, patient access staff would call in for notification, but in the meantime, the radiologist would sometimes change the order. "The order would come down for CT of the head, and then, the radiologist would protocol the order and say they also need a CT of the brain. So we had to add that on, which was causing numerous denials," says Brooks.

Patient access is currently working out a process where radiologists contact them before the service is performed. "That way, we can change the notification number, which obviously has to be right on the mark," says Brooks. "We are trying to work out a process where the ancillary service can tell us upfront what services are actually going to be performed."

In the meantime, the hospital's IS department created a report for this process, so that the payer is contacted to change the authorization, in order to reduce the denials. "We do reports for radiology so they can see what it's costing us. We are showing them the losses in their revenue," says Biegler.

This "really got the attention" of administration, says Bielger. "That's why they have given us an edict to work with other ancillary areas so we can get these losses down," she says.

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Zero in on the registration errors being made by staff

You'll have more ability to collect

To increase collections, you need accurate information at registration. "Billing accuracy affects your ability to collect," says **Cathy Foster**, director of revenue cycle at St. Joseph Medical Center in Towson, MD. "If we don't get accurate insurance information, then we can't check the benefits and copay. And if the patient doesn't find that information out ahead of time, they are less likely to pay."

Last fall, Foster's department implemented an automated system to improve registration accuracy. "We are getting prepared for electronic eligibility, which will help with registration accuracy also," she adds.

With the new system, when registrars enter insurance data, it will come back saying the insurance is either good or bad. Currently, registrars have to either call the payer or go on the web site to check, which delays the registration process. "But on the flip side, this technology also costs the hospital something," Foster acknowledges.

These factors trigger quality review

At Palmetto Health Richland in Columbia, SC, patient access uses a manual process for tracking registration accuracy. "The manual process works well — it just does not give us the opportunity to identify the errors and correct them earlier in the revenue cycle," says **Charlene B. Cathcart**, CHAM, director of admissions and registration.

The department's goal is to have all registration-related errors identified and corrected prior to the billing process — normally by the fifth day after the discharge date. "There are several

excellent quality systems available. We are considering purchasing one once capital funds are available," says Cathcart. "We have delayed because there are other systems that we wanted to implement to help us provide better care to our patients."

A quality review is done by one of the department's two education and training specialists, triggered by any one of several factors — a failed billing report, a failed claims report, work lists from the Financial Clearance Workstation product, or feedback from the patient account department. For failed bills or claims, the below items are reviewed:

- county code;
- employer name and address;
- incorrect insurance;
- insurance address;
- insurance sequence;
- insured information;
- marital status;
- Medicare Secondary Payer Questionnaire;
- information received from the electronic verification system;
- no insurance loaded;
- occurrence codes;
- patient demographics;
- policy numbers;
- ethnic origin (reported to the Department of Vital Statistics);
- relationship to insured.

Also, 20 accounts are manually reviewed per month, checking the accuracy of employer name and address, the Medicare Secondary Payer Questionnaire, occurrence codes, patient demographics, relative/emergency contact, social security number, insurance plan/policy number, whether the second insurance was not loaded, and information received from the hospital's electronic verification system.

"The most common error is missing occurrence codes, specifically related to the patient and spouse's date of retirement," says Cathcart.

All of these data are entered into an access database, and at the end of the month, each employee is given a quality review report, which they call a "report card." If the employee has 97% quality or greater, they are recognized with a meal ticket. If the employee has less than 97% quality, they are referred back to the education department for a refresher course.

"If average quality year to date continues to be below our expectation of 97%, corrective action steps are taken," says Cathcart.

At. St. Joseph, errors made by registrars are routinely monitored by a patient access trainer.

"Also, registrars are able to sign in themselves and see what their errors were for the day," says Foster. "They are required to go in and do this. Our trainer can tell whether they have looked or not."

The monitoring has markedly improved registration accuracy, says Foster, partly because the registrars know somebody is looking at their errors. "For the most part, they want to do a good job and the trainer doesn't have time to look through every single registration and find errors on a daily basis. This way, the system finds them for them."

For example, the system will pick up errors such as a Medicare number without enough digits or missing the prefix or suffix. "These typo errors occur because they were trying to get the registration done quickly. Now they can go in and correct it before the bill drops, because we have a four-day bill hold," says Foster. "So it has not only impacted registration accuracy, it has also impacted billing accuracy."

Currently, registrars are not incentivized in any way. "So we are relying on pride in doing a good job. And our trainer is very good about giving positive feedback," she says.

Instead of giving registration staff feedback only when errors were made, the trainer also lets them know when their accuracy is very good, often by sending out a group e-mail. "And they appreciate that," she says. "She lets everyone know if someone has been outstanding, and congratulates them."

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Are complaints piling up? First find out the facts

Tell employees what they must do to change

Vicki Lyons, patient access manager at Baptist Hospital East in Louisville, KY, says that she goes to "every extreme" not to have to terminate an employee. That means always taking the time to find out the facts, whether a complaint comes from a patient, family member, or another hospi-

tal employee.

"I have called patients at home before to see if I can obtain more information on an incident," says Lyons. "I want to have all the facts before I confront the employee."

When multiple complaints come in for one particular employee, you should investigate by "interviewing the complainers," says **Antionette Anderson**, CHAA, CHAM, director of patient access & centralized scheduling at Skaggs Regional Health Center in Branson, MO. "Ensure that what they are saying is true. Also observe the employee that is being complained about."

Lyons says that she takes all complaints seriously. "You have some patients that just like to complain. But if it is something that bothers them, then it is worth looking into," says Lyons. "It may provide opportunities to change our process for the best to take better care of our patients."

Should a second chance be given?

Anderson says to take these steps after you get a complaint: Counsel the employee and find out why the situation happened, explain how things could and should be handled differently, complete a formal corrective action plan, and revisit with the employee within a week to see if things are better and how you can assist.

Anderson says she believes in a "three strikes and you're out" policy.

"Everyone deserves a second chance unless the employee has done something illegal, unethical, or intentionally meant to harm someone," she says. "But if we have worked with the employee and counseled them and they do not show any improvement or willingness to improve, termination is warranted."

Katie M. Davis, director of patient financial services at Carolinas Medical Center in Charlotte, NC, says that if someone comes in to complain about a co-worker, her first question is whether they have discussed it with the person they are complaining about. "Many times, issues can be resolved on a one-to-one level without management being involved," she says. "If the person is reluctant to approach their co-worker, I then investigate the incident as the situation warrants."

Getting the employee to "see" the issue is the only thing that helps turn a bad situation around, says Davis. "I'm not sure that 'second chances' work. An employee has to have a clear understanding of the root cause of the problem and what they need to do to correct it," she says.

The following steps occur if there are problems with an employee, says Davis: First, the employee is counseled. If the behavior does not stop, the next step is a verbal warning, followed by a written warning, a final written warning, and then termination.

"At any point in the process, we can skip a step if the behavior is egregious," says Davis.

When an employee receives counseling, an improvement plan is put into place with specific action items to help the employee improve. There is also a follow-up date for the employee and manager to sit down and discuss the employee's improvement — or lack of improvement — and any additional action steps that need to be implemented.

Davis says that a patient access manager's role is to support the employee and provide the tools to help them improve, but success or failure is ultimately the employee's responsibility.

"I have had employees who changed their behavior and have seen them become very successful," she says. "I have seen others who have not taken the responsibility for their actions continue to have problems and ultimately were terminated."

Use a self-improvement form

Suppose that a patient access employee has gotten several complaints from other departments about a rude attitude. These were addressed previously and yet, it has happened again. In this situation, at Baptist Hospital, the employee signs off on a written self-improvement plan.

"We then have documentation — the employee has signed it, and if the issue continues, then further action is taken," says Lyons.

On the self-improvement form, the employee is told the issues that need to be corrected in a certain amount of time and is informed that if improvement is not shown then further action may be taken. "A couple of weeks before the time would expire, we re-visit with the employee to let them know how they are doing and see if they have any questions," says Lyons.

The form includes this information:

- employee name;
- position title;
- date;
- period covered;
- areas of deficiency;

• required corrective action;
• intervals at which re-assessment will be scheduled;
• employee signature;
• department manager's signature.

The form also states: "Failure to improve according to the guidelines of this performance improvement plan may lead to discharge. It is expected that the performance outlined on this improvement plan not only improve during the time period defined but also remains at an acceptable level after successful completion of the employee performance improvement plan. If performance deteriorates to an unacceptable level within a reasonable period of time and there is evidence of ongoing performance problems, the employee may be discharged without further performance improvement plans."

"I think that in writing up the self-improvement plan, the employee also knows that we are serious when we say their customer service has to improve," says Lyons.

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If complaints are piling up, talk to staff directly

Don't terminate anyone before you do

Considering the amount of turnover in the average patient access department, the last thing you probably want is to lose a staff member. However, there are times when a staff person has to be terminated — never a pleasant task, but at times, a necessary one.

"It has been my experience that health care managers will sometimes subscribe to the 'warm body' theory, which is that having someone is better than taxing your good staff with extra hours," says **Michael S. Friedberg**, FACHE, CHAM, associate vice president of patient access services at Apollo Health Street and author of *Staff Competency in Patient Access*.

Both sides of this discussion have their advantages and disadvantages. "But I would lean toward not keeping ineffective or incompetent staff members employed due to the fear of not being able to easily replace them," says Friedberg. "This sends the wrong message to your hardworking and dedicated staff."

On the other hand, you may get a pleasant surprise if you ask an employee for his or her side of the facts. On one occasion, Friedberg got a complaint about a financial counselor from a manager who said, "I'm at the end of my rope; this person's got to go."

"So as I always do when I terminate somebody, I went to talk to them. I asked her if she could tell me why she was rude to a particular patient and she said, 'I didn't mean to be rude, but I take care of as many patients as I can in a day, because these people really need charity care, and I don't want to hear their life story about when they were a little boy. I want to get the facts from them because I don't want somebody to have to come back tomorrow because we couldn't process them today.'"

"I said, 'I'm not firing this woman, that's a really good answer,'" says Friedberg.

While the employee's manager moved on, the employee is still to this day the supervisor of the financial counseling area.

"What I was able to do was cut through the office politics and the 'I don't like this person' dynamic that was going on. I was able to recognize that this was the kind of person I wanted on my team," says Friedberg.

Friedberg says that by bringing the employee in to talk, "that was the right opportunity for her to come out of her shell. She was given the chance to show what she could do. At the end of

the day, she got it. Initially, I thought she was rude, she needs to go. But that was not the case."

As a patient access professional, sometimes you have to take a step back and ask "What are the skills that this person needs? And what have we instructed or asked them to do?" says Friedberg. He says that perception is not always reality. "The perception of this employee was that she was rude, but she thought that she was doing her job."

Another thing that the woman said which surprised Friedberg was "please don't fire me. I love my job and I want to work hard for these patients."

Just because somebody is complaining, doesn't mean that their complaints are factual. "Sometimes those are the people you want to spend a bit of time with," says Friedberg. "Sometimes you get a gem."

Replacing people is costly, both financially and in terms of staff morale, says Friedberg. "I have always been at peace with terminations because I am honestly able to tell myself that, 'There isn't anyone I terminated that didn't earn it.'

"To be honest, I give people too many chances sometimes. I have stuck my neck out for people who ended up disappointing me. But those are the minority, and I'd rather take the chance," says Friedberg.

It's also possible that a fired employee will learn from his or her mistakes — even if it's after they leave your department. Friedberg recalls an occasion where a registrar said to him, "I'm here because you're going to fire me, right?"

"I said, 'Look at the evidence," and she cried and said to me, 'You know what, you're right. I'm sorry I let you down and I really learned something from this experience.' Last I heard, she was doing something else really great."

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