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When doing more with less during recession, patient safety is a concern

Automation and education should not be skimped on

Due to the economic downturn, patient access departments are being asked to maintain programs with fewer resources and do more with less. Technology investments are being put off, and staff in some cases are being cut.

In this scenario, "providing excellence becomes even more important" for patient access, says **Julie Johnson**, CHAM, director of health information management at Mt. Graham Regional Medical Center in Safford, AZ.

"Getting the right information the first time and ensuring quality of information becomes an opportunity to help the organization survive during a recession in reduced denials and re-work costs," says Johnson.

Johnson says that about 2,200 workers have been laid off in her community, which has a direct impact on the patient access department. "These people have different severance packages, which all include COBRA that is paid for by the company," she says. "It is up to us as access professionals to guide patients to the benefits they still have."

Johnson says that one of the most important things you can do for your patient access staff is to help them with their own financial difficulties through training.

"When someone's spouse has been laid off, the work is not the first thing on their mind, but rather their own financial problems are the focus," says Johnson. "We are helping staff members by pointing them to free resources on the Internet about how to get out of debt and stay that way."

When budget cuts occur, usually the first item cut is training and education. "But if organizations will invest in their staff, the organization will be more likely to flourish during a recession because of the new information and morale-boosting that occurs when staff feel valued," says Johnson.

If you do have to downsize, Johnson recommends getting your team together to ask for ideas. "Give them the scenario: 'We must cut one FTE. How can we creatively do this?'" she suggests. "If everyone were to give up one hour of work to save one FTE, that would be one way to solve the problem."

Belva Denmark Tibbs, vice president of medical operations of Kaiser Permanente in Cleveland, says that the current economic downturn has affected members, most of whom have employer-sponsored insurance. "We have noticed a higher involuntary termination rate due to company downsizing or changes in company-paid health benefits," says Tibbs.

Tibbs says that for patient access directors, it is important to agree on what is most important to your area — such as quality, service, or regulatory requirements. "Once you have identified the critical components, engage physician and frontline staff in candid discussions on how to do more with less," she says. "This is a great time to think small."

Tibbs says that the important thing is to "communicate, communicate, communicate. Tell people 10 different times 10 different ways about the reason for the budget cuts, enumerate the changes, and invite the staff to be part of the process," she says.

Obtaining feedback is invaluable, says Tibbs, as you and your team make tough decisions to meet budgetary constraints. "Keep staff and key stakeholders apprised of budget cuts and their intended impacts. Survey stakeholders to ascertain any *unintended* impacts of your decision."

Consolidation is key

If you're facing budget cuts, consolidation of patient access registration locations is a must, says **Katherine Murphy**, CHAM, director of access services at Nebo Systems, a subsidiary of Passport Health Communications Inc. in Oakbrook Terrace, IL.

"This creates more coverage for continued excellent service," says Murphy. She recommends:

- cross training staff, not only in multiple roles, but in multiple locations;
- preregistering patients during the scheduling process;
- eliminating decentralized registration areas as much as possible.

Exploring automation to solve time-consuming activities is another good prospect. "An example of this is the manual quality assurance process that is so prevalent in the industry," says Murphy. "Automating this process is highly productive, and, in many instances, provides the user with instant results and directs them as to how to correct any errors."

It is highly unlikely, says Murphy, that a manual process can cover every registration data element, let alone make the necessary correction prior to billing the claim.

"This could result in payment delays, reductions, or no payment if it becomes a stale claim," says Murphy.

Keep morale up while downsizing by eliminating positions as they become open, says Murphy. "When supervisory positions become open, consider hiring people who would function at a lead or coordinator level instead."

One thing that you should *not* skimp on is the staff education budget, warns Murphy. "That is one area that helps keep the doors open and the money coming in," she says. "Continue to take time to celebrate successes, even if in little ways.

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Communicate and be highly visible to the staff. They need your support more than ever!"

ROI is your best defense

"Unfortunately we are in a position where you have to sometimes spend money to make money," says Murphy. "Showing ROI [return on investment] for technology can be the key to not cutting it off or inhibiting its implementation."

You'll also want to provide information showing the impact you have on patient service, throughput, and wait times. "Ultimately, we do not want patient access to become an area where patient safety is also an issue. This can easily happen when we start to hurry," says Murphy. "Mistakes can get made there that can trickle down to the ancillary departments."

Murphy recommends referring to the cost of billing the wrong insurance, or a dissatisfied customer who talks to 10 of his friends. "ROI is out there in many forms," she says. "It is one of our best defenses."

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Key indicators can prove worth of access

A focused approach is often lacking

(Editor's Note: This is a two-part series on use of performance indicators in patient access. This month, we cover their benefits and how to develop the most effective scorecards. Next month, we'll report on how to use these data as a tool to motivate your staff.)

Keeping a close watch on key performance indicators (KPIs) can help you do a powerful thing: namely, demonstrate your impact on the hospital's bottom line. You can do this in terms of customer satisfaction, financial outcomes, process compliance, and organizational development.

KPIs also can help you confront a common problem in health care organizations — the fact that patient access may be "understaffed and over-utilized," says **Jeff Roche**, a manager at Accenture's Lancaster, PA, office. Roche has worked with a number of hospitals to develop KPIs for patient access.

"Many organizations have been unable to adequately monitor and measure important statistics that drive patient access results," adds Roche.

These things have not been easy to measure. This is largely due to the fact that many legacy systems do not capture the necessary data to report the KPIs, such as dollars collected by patient access vs. expected payment, error rates, or the percentage of patients who are pre-registered prior to arrival.

"Unlike billing or coding functions, the volumes for patient access can be intangible, as with walk-ins or direct admits," notes Roche. "Thus, many organizations have not pursued a focused approach to patient access KPI management."

Make informed decisions

Roche says, however, that organizations that *have* chosen to invest in measuring and monitoring KPIs have seen significant benefits.

Roche explains that many organizations choose to first pursue key performance indicators implementation for their dedicated revenue cycle patient access staff, in areas such as centralized financial clearance or centralized registration.

"By setting baselines and monitoring for their own staff, it becomes easier — and strengthens the case — when the KPIs are shared with ancillary departments performing similar functions," says Roche.

Through this approach, data quality can be monitored across the organization, and appropriate actions can be focused to the appropriate departments and/or functions.

"Further tailoring the detailed reporting to applicable sites of service or functional areas provides the tools for effective decision-making and sets expectations for communication and accountability," says Roche.

Not an easy undertaking

At the organizations Roche has worked with, increased focus on KPIs on the front end have led

to increased point-of-service collections, improved data accuracy rates, reduced insurance payer rejections and avoidable write-offs, and improved patient/customer service scores.

"This is not an easy undertaking. It requires support and involvement from IT, as well as a time investment from patient access leadership," Roche acknowledges. For instance, there must be constant monitoring of your chosen indicators once baselines have been established.

Roche says that a "robust" KPI focus on the front end gives you the ability to make informed decisions, strengthened by strong data sets rather than assumptions.

For instance, by measuring data accuracy, you're able to identify strong, productive team members. By measuring point-of-service collections and reduced avoidable write-offs, you can demonstrate the improved financial performance of your department.

Frank Danza, vice president of revenue cycle management at the North Shore-Long Island Jewish Health System, says that performance indicators are used for the elements of access functions that have "the greatest impact on revenue cycle performance and cash collections."

For all scheduled visits, the following are measured at North Shore-Long Island Jewish:

- the percentage of cases where patient access staff completed pre-registration activities prior to service. (This means that staff contacted the patient and confirmed demographic and insurance information);
- the percentage of cases where staff completed notification activities to the patient's insurance company prior to service;
- the percentage of times that an authorization is received prior to service for emergency admissions;
- the percentage of times that an authorization is secured within 24 hours of admission.

The hospital is implementing a process for treat-and-release patients in the emergency department (ED), which also will be tracked. "Our goal is to meet with all patients as they exit the ED to confirm demographic info and insurance information, and to educate self-pay patients on financial assistance options," says Danza.

Link patient access to corporate goals

Danza says that the patient access indicators directly link to the organization's corporate revenue cycle goals. For instance, cash collection goals, denial goals, and write-off goals are tracked for every hospital and reported every month.

"We have identified many types of improvement opportunities," says Danza. These include:

- the need to increase staffing in select functions;
- the need for additional training on verification requirements and changes;
- the need to counsel staff about productivity and quality;
- the need to improve the interaction between the completion of these revenue-related activities with the registration process, "which very directly impacts the patient experience," says Danza.

John Woerly, RHIA, CHAM, senior manager at Accenture in Indianapolis, says that performance scorecards can link a service area, such as revenue cycle, with the organization's corporate goals. This is achieved, he says, through shared outcomes.

"The revenue cycle is a complex, interdisciplinary process that touches many parts of the organization," says Woerly. Your approach to assessing the performance of the revenue cycle and evaluating alternative solutions, says Woerly, should be three-fold: First, assess your current outcomes; next, identify where there is "financial leakage"; and finally, identify the causes of the leakage.

What exactly should you measure?

Performance scorecards can and should play an important part in the development of process improvements in your patient access department. "Scorecards should be limited to those things that are most essential to showing how the department is performing," Woerly says.

These may include:

- **Customer satisfaction:** Measure patient complaints and also positive comments made by patients about patient access staff.
- **Financial operations:** Track point-of-service collections, patients who were discharged but not final billed, and days in accounts/receivable.
- **Process Compliance:** Measure work volumes — appointments scheduled and pre-registrations performed — and also organizational development including staff productivity, promotions, and retention/recruitment. **(See sidebar, pg. 30, on how to develop a scorecard, and sample patient access scorecard, pg. 29.)**

When setting up your scorecard, Woerly says ask whether the indicator does these things:

• aligns senior management team around the company's strategy;

• provides a vehicle to communicate the strategy to all employees, align the team around drivers of performance, and gain accountability for desired performance;

• provides a mechanism for learning and feedback;

• becomes a management tool for decision-making;

• provides a means for identifying and prioritizing initiatives;

• promotes accountability and follow-up;

• makes explicit team contributions to the strategy;

• improves management development and coaching, based upon strategic performance drivers linked to the scorecard. ■

Address these things *before* you create a scorecard

John Woerly, RHIA, CHAM, senior manager at Accenture in Indianapolis, advises considering these items when developing a scorecard for your patient access department:

1. Identify all of your available data and data sources, both internal and external.

External benchmarks may be derived from the National Association of Healthcare Access Management, the Healthcare Financial Management Association, and *Hospital Accounts Receivables Analysis* — as well as from your own professional contacts.

2. Decide on your implementation approach. You can do either a "big-bang" approach or a pilot/phase-in. The pilot/phase-in approach could take the form of creating a scorecard for one or two functions within the department,

Sample simple patient access scorecard

Indicators — Patient Access	Actual	Target
Pre-Scheduling of Outpatient Cases		> 80%
Financial Clearance of Scheduled Outpatient Cases		>95%
Financial Clearance of ALL Outpatient Cases		>80%
AR Days		<50 Days
Net Denials as % of Net AR (Initial Notification)		<1%
Registration Accuracy		>98%
Final Bill Holds attributed to Patient Access		<5%
Discharged Accounts Unverified		<2%
% of "Clean" Accounts Passing Patient Financial Services Edits		>80%
% of Duplicate Medical Records		<2%

Source: John Woerly, RHIA, CHAM, Accenture.

such as pre-service/financial clearance or upfront collection activities. In contrast, the "big-bang" approach would look at creating a scorecard for the entire revenue cycle operation — patient access, medical records, and patient accounting.

3. Ask for feedback from users.

Obtain input from two groups: employees who will be performing the data entry and those who will be receiving the scorecard. "Distribute a first draft. Then receive feedback on the draft scorecard and make updates," says Woerly. This will ensure that you have the input of key stakeholders, as well as obtain their support and buy-in.

It also is essential, says Woerly, that you choose performance indicators that are easily measurable

Don't omit important pieces of information

When developing a patient access scorecard, **John Woerly**, RHIA, CHAM, senior manager at Accenture in Indianapolis, says it is "essential" to document measurement methods, data sources, reporting devices, reporting frequency, and distribution pathways. The below sample, developed by Woerly, shows how to document this information:

Patient Access Performance Indicators	Minimum Standard	Measurement Method	Data Source	Reporting Device	Frequency	Distribution
Registration Data Integrity	• >98% accuracy of critical data elements • 100% data entry of all missing data elements within 24 hours of patient arrival	• Team Leader Quality Control • Missing Data Element Report from PreBilling Rejections	System Report 9931 Face sheets	• Access Indicator Report • Associate Performance Profile	Weekly	Manager, Hospital Business Office Asst VP, CBO
Pre-registration Activity	>95% of all non-emergent, scheduled cases	Automated Quantitative Examination	System Report 9922	• Access Indicator Report • Associate Performance Profile	Weekly	Manager, Hospital Business Office Asst VP, CBO
Insurance Verification	• 100% of all IP cases within 24 hours of admission • 100% of all OP cases with estimated charges >$350	Automated Quantitative Examination	System Report 9922	• Access Indicator Report • Associate Performance Profile	Weekly	Manager, Hospital Business Office Asst VP, CBO
Insurance Denials (Pre-certification)	50% Reduction of Baseline Registration Related Insurance Denials	Automated Quantitative Examination	System Report 9945	• Access Indicator Report • Associate Performance Profile	Monthly	Manager, Hospital Business Office Asst VP, CBO
Upfront Collections at Time of Service	• Collect from all Medicare and Managed Care patients • 100% collection of $5-25 co-pays • 20% collection of estimated commercial payments	Manual calculation	Collections Log	• Collections Log • Associate Performance profile	Weekly	Manager, Hospital Business Office Asst VP, CBO

Source: John Woerly, RHIA, CHAM, Accenture.

and available — getting feedback from your key stakeholders should assist in this.

4. Take steps to reduce the amount of manual data entry that will be required.

Identify any available automated methods to obtain data.

5. Ensure that data are retained, in the event that information has to be reproduced or re-evaluated in the future.

Keep records of the source documents you use, including system reports and internal statistics.

6. Remember that the scorecard may "evolve" and be updated over time as new indicators are added or modified.

"If formulas and content change, keep records of those changes, so that if you are comparing outcomes over years, you don't mistakenly forget changes that have been made," says Woerly.

For example, your up-front collections in 2007 may have only included co-payment collection in the ED and ambulatory surgery, whereas up-front collections in 2008 include co-payment, deductible, and co-insurance collection in all registration areas.

7. Keep it simple and keep it meaningful.

"Scorecards can be as simple or as complex as required. Sometimes, keeping it simple is the best. Don't collect data just to collect it!" says Woerly. "Use it to motivate staff and to show your administration the improvements that have been made in your operations."

8. Use data to identify areas for improvement.

"Once you report out for at least six weeks, you'll have your baseline data and can start reviewing for trends — both good and bad," says Woerly. At this point, you will likely find many opportunities to make improvements, he says, in areas such as up-front collections, pre-bill holds, financial clearance compliance (pre-registration, insurance eligibility/benefit verification, pre-certification/authorizations, referrals, patient liability estimation, and upfront collections), and denial reduction.

"Information should be shared and posted to hold all staff accountable," says Woerly. "It can be utilized to track performance, as well as to make further improvements."

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New skill sets that patient access needs — right now

Focus is shifting to the front end

Right now, patient access managers are in a difficult situation — their roles and responsibilities, already very broad, are "changing on a regular basis," says **Ed Erway**, chief revenue officer at University of Kentucky (UK) HealthCare in Lexington.

Providers are being forced to deal with increasing co-pays and deductibles, health plan complexity, and more uninsured patients. This means that the focus of accountability for payment and collection of valid data must switch from back-end billing to the front end — in other words, to patient access staff, says Erway.

"This change will require patient access personnel to possess the technical skills of communication, attention to detail, and basic health science," says Erway. "They must also have the ability to multi-task with many new technologies."

Erway adds that higher-level degrees or certification in patient access will be helpful to promote these skills.

According to **Jodie Martin**, the organization's director of hospital admitting, "As the diversity of our population increases, there is also a need for bilingual and multilingual patient access personnel." Martin says that the organization's learning center offers classes on basic Spanish, and patient access staff are encouraged to participate.

Make new roles work for you

There is no question that the financial focus at many hospitals is shifting — from receivable collections to front-end collections. Very likely, this means that your patient access personnel need both new technology and new skills — to help them verify insurance benefits, addresses, employers, referring physicians — and the need for health care services.

It's true that this trend means extra workload for patient access. However, it also could be an

You need to co-exist with business priorities

Patient care and business priorities can co-exist as equal partners, says **Jodie Martin**, director of hospital admitting at University of Kentucky (UK) HealthCare in Lexington, but "it's up to the patient access manager to facilitate that partnership."

The key to this collaboration, says Martin, "is first and foremost the commitment of executive leadership."

"At our institution, this commitment has resulted in increased opportunities for business and patient care staff and leaders to work together on the mutual goals of excellent patient care and the reimbursement for that care," says Martin.

Martin says that the hospital's physician leadership is very knowledgeable about business priorities, and they are also accessible.

"It is up to patient access managers and directors to take advantage of that accessibility to seize opportunities to enhance collaboration," says Martin.

Martin recommends the following to improve collaboration with physician leaders:

- Request meetings with individual physician leaders to ask for their feedback.
- Let them know your willingness to work with them to provide the best experience for their patients.
- Listen to their ideas.
- Offer to participate in work-groups or committees that impact the organization.
- Use e-mail and other networking tools to remain visible and accessible.
- Seek out opportunities to increase your knowledge.

"Do not confine your learning to just the business aspects of the organization," says Martin. "I often make notes of topics or terms that I hear clinical staff use during meetings. I then come back and 'google' these topics to learn more."

Knowledge and credibility are essential skills for successful negotiation.

"It is important to vet any proposed changes thoroughly in the organization in order to get buy-in from the stakeholders," says **Ed Erway**, chief revenue officer at UK HealthCare.

At the same time, the business leader must show his or her willingness to eliminate any barriers to patient care that may be due to registration processes or procedures.

"The patient access leader of today has to demonstrate creativity and determination, and be an active partner in their relationship with their medical colleagues," says Martin. ■

opportunity to obtain more resources for your department. "The work is shifting to patient access," says Erway. "However, forward-thinking providers will also shift the resources to go with the workload." **(See sidebar on co-existing with the organization's business priorities above.)**

The goal, says Erway, is to achieve the "best possible efficiency" in getting pertinent information verified correctly in the beginning of the patient's stay, instead of applying resources after the patient has already received their services.

UK HealthCare is going through a new system selection process for patient scheduling and registration. "One of the critical components of the evaluation will be insurance benefit verification, address verification, and credit history," says Erway.

In the meantime, the department plans to install an insurance verification module with its current system. "This will not meet *all* the business requirements we have. However, it will allow for a more comprehensive approach than we have today," says Erway.

Accuracy, but with less interaction

Martin says it's important for patient access managers to take note of two other health care business priorities: customer service and patient convenience.

"Institutions must come up with processes and technical solutions that allow patients to register remotely or via kiosks, so they can report directly to their procedure areas without having to stop at patient access stations," says Martin.

A hospital committee is currently exploring the use of kiosks for registration at UK HealthCare. "We are at the stage of defining the functionality," says Martin.

She says that she hopes to end up with a

product that interfaces with the existing registration system, allows patients to enter or scan their basic demographic and insurance information, accepts co-payments, provides copies of standard notices, activates pre-registered accounts, and if necessary, activates interpreter services.

You'll need to ensure the accuracy of demographic and payment insurance at a time when there will be *less* face-to-face interaction with the patients themselves.

Both technology implementations and process changes are necessary to meet this challenge. For example, technology may provide patients with the ability to scan demographic and insurance information through the use of a health care ID card, says Martin. Likewise, enhanced pre-registration processes will allow for more complete data-gathering processes, with a comprehensive eligibility and address verification system as a necessary component.

Another big challenge: the need for a much speedier process. This is becoming more important as more and more clinical information systems are implemented and integrated with patient access registration systems.

"Delays in registration can mean delays in the start of patient care," says Martin. "All patient access managers must creatively design their departmental processes to address this issue," she says.

Martin says that the organization's planned upgrade of its registration system is going to enhance its "quick reg" process for emergency department patients. The new function decreases the number of screens that the registrar has to go through to do a basic quick registration.

"The improvement will decrease registration time by several minutes," says Martin. "There is a commitment at the enterprise level to improve our pre-registration processes. The focus is on pre-clearance and pre-registration for all scheduled patients."

Martin estimates that about 60% of scheduled patients are currently pre-registered, with very basic demographic and insurance information.

"Our goal is to both increase the number and the comprehensiveness of pre-registrations through the use of better systems, staff programs and requirements, and standardized processes," says Martin. "Ultimately, we hope to be in the 95% to 98% range of scheduled patients being pre-registered."

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Are registrars uncomfortable asking patients for money?

You'll need new training approaches

Patient access departments are increasingly focused on upfront collections. Yet staff thrust in this new role often are somewhat uncomfortable with asking patients for money.

"This once was a standard practice decades ago, but then went out of vogue. It became almost insulting to ask patients for money," says **Katherine Murphy**, CHAM, director of access services at Nebo Systems, a subsidiary

Four ways to improve your ability to collect

Fewer resources, service discounts, high deductibles, transparency, increased market competition, and increases in the uninsured population. These factors make it "ever so critical to collect during the upfront processes," says **Katherine Murphy**, CHAM, director of access services at Nebo Systems, a subsidiary of Passport Health Communications Inc. in Oakbrook Terrace, IL.

To improve staff's ability to collect:

• When hiring, don't forget to include collection in the job description.

"Keep in mind that future hiring practices should include seeking candidates with skill sets that are key to this responsibility," says Murphy.

• Obtain buy-in of external department staff.

It is not helpful to the process if a registrar is charged with collecting emergency department copayments when the department's discharge practice is to bypass the registrar or cashier charged with this initiative.

Murphy says she once worked with a provider that developed an incentive program for the emergency department clinical staff. Each time they escorted the discharged patient back to the collection area, their name was entered into a weekly raffle drawing.

• Post signage for walk-in patients.

As they arrive, these patients are given the opportunity to read the expectation of payment. "Perhaps begin with asking for the full amount due, but then ratchet down to a minimum deposit due," suggests Murphy. "Remember, many providers now offer self-pay and prompt-pay discounts. This should always be discussed with the patient."

Without automation, notes Murphy, it can be difficult to drill down to the amount owed quickly and accurately, which negatively affects patient throughput.

• Offer online training to staff.

Peter Savini, vice president of revenue cycle management at Catholic Health Initiatives, says that a comprehensive online training course was recently developed, due to an increased emphasis on front-end collections at his organization.

The goal of the training is to improve customer service, and answer the question: "How do we have this conversation with patients at the point of service?"

"Each of our market-based organizations will identify representatives within their access area who should be required to take the course," says Savini.

The course was developed in-house based on feedback from local and national access staff at the organization's facilities. Each facility gave input about the tools that would be most helpful in overcoming existing barriers representatives faced when engaging patients in dialogue as they paid at the point of service.

Savini says that by and large, the biggest barrier was one of "culture."

"We have many small critical access hospitals and mid-size sole community providers," says Savini. "Traditionally, our access representatives did not engage in these types of conversations in the past. Simply asking them to begin to do so, without providing necessary staff training and communications to the community, would not be setting ourselves up for success."

The training includes scripting, role-playing, quizzes, and tests. The number of access staff trained will depend on the size of the facility. "On average, we expect two to five representatives to be trained per facility," says Savini. "We can track this through our in-house e-learning tools."

This way, patient access managers can keep track of which staff took the training course, and which did not but were required to based on their position. "The scores of the representatives are also tracked," says Savini. "This allows us to provide additional training where scores indicate it may be needed." ■

of Passport Health Communications Inc. in Oakbrook Terrace, IL. "Now we have to have that flexibility again, and we are relying on the people in the front to have the skill set to do that. They need the ability to show empathy *and* collect money from sick people." **(See sidebar, above, on improving staff's ability to collect.)**

This particular skill is more important than ever, emphasizes Murphy. "We are in an industry and economic climate that demands we change how we do business in health care. I have seen hospitals in the Chicago metropolitan area close their doors!" she says. "We have to step up to the plate and make change happen."

You'll need to do three things, says Murphy: Coach your existing staff, recognize your "super

star collectors," and create incentive programs for everyone involved the process.

If staff are uncomfortable in this role, this can have an adverse impact on collections, according to **Peter Savini**, vice president of revenue cycle management at Catholic Health Initiatives. "They will either avoid the discussion altogether or become discouraged when patients challenge them," he says.

Your goal: No surprises

Along the pre-access path, collection can be structured in a variety of ways. For example, at the time of scheduling and preregistration, an estimate for the service or expected balance due after insurance can be provided. This can be done either via a manual process or with an automated payment estimator.

"The first attempt to introduce the concept that a payment is expected could be done at that time," says Murphy. If the payment is not completed, then a call can be made to patients reminding them of their appointment. At that point, another attempt to collect, or discuss financial assistance, can be made.

At that point, if you are still not successful in collection, patients can be reminded of the fact that payment will be expected at the time they check in for their appointment.

"Patients are used to paying by phone when ordering from a catalog, or may routinely pay for purchases online," says Murphy. "Now it's health care that will be in this mix. With today's automation, a patient can even pay online before an appointment, in the most-wired scenario."

The idea, says Murphy, "is to not surprise the patient when they arrive for service."

To make the most of collection opportunities, patient access managers need to minimize the impact on staff. You can do this, says Murphy, by providing two things: automation and user-friendly processes.

"It is not just scripting and customer service training that is important," says Murphy. "It is creating best practices that make the collection process easy. That includes informing the patient before arrival when possible."

This "minimizes any negativity and stress on everyone involved in the process," says Murphy.

Without automation, staff may end up searching through a chargemaster, because they are not clear on pricing bundled procedures or missing the calculation of certain costs, such as contrast material.

"Automation also allows for easier tracking of payments and collections for employee incentive programs that should be considered as a part of this," says Murphy.

Share collections data with staff

After Kaiser Permanente Mid-Atlantic Region in Rockville, MD, implemented a regional point-of-sale system at its facilities, increased collections were seen. "In addition, staff became more aware of the importance of copays," says **Tanya M. Edelin**, director of cash collection & systems.

A dashboard was created to monitor collections, including the percentage of copays collected by staff. "We use that information to drill down and determine if there are any issues we need to improve on so that we can better collect," says Edelin.

Occasionally, the data will reveal the need for additional training for staff on a given patient's benefits and what the patient will owe.

"As our tools to predict patient liability were enhanced, staff's level of comfort to request money became a non-issue," says Edelin.

For the first time, staff had accurate information about what to collect from the patient for all types of payer plans, including high-deductible plans, which may result in payments due at the end of a visit.

"Prior to implementation, we weren't doing the best in terms of upfront collections," says Edelin. "In the past, revenue collection wasn't considered a fundamental part of providing patient care. What we are driving forth is that as a part of your performance, not only is there a clinical expectation, but there is also a financial expectation — to charge patients appropriately."

COMING IN FUTURE MONTHS

- Don't lose your best patient access staff members
- Give staff these incentives to improve collections
- Collaborate with business leaders at your organization
- Get dramatic results by automating quality assurance

The idea is that patient service encompasses a whole list of components, not only "Did I get them into the doctor on time?" says Edelin.

First and foremost, staff are trained to be patient and respect the confidentiality of the patients they are speaking to, says **Karen Pugh**, the organization's medical center administrator.

"Staff defer more in-depth conversations to member services or patient financial services," says Pugh. "We also partner with our revenue cycle experts to engage staff on the importance of revenue collections."

Initially, training consisted of targeted application navigation. However, this has progressed to "building an understanding of the business case for revenue collection," says Pugh.

Kaiser uses an interactive, real-time approach, which explains the fundamentals of revenue collection and how the roles and responsibilities of each health care team member impact the revenue stream.

"As we move forward, we're looking to build more interactive and online tools that will allow training to be ongoing and proactive," says Edelin. "Revenue collection is emphasized as fundamental to the business."

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