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Be creative to maintain staff training even in the face of drastic budget cuts

A chance to 'grow your staff' under bad circumstances

Many patient access departments are facing two opposing pressures right now: They are being asked to improve collections and help the hospital's bottom line, while at the same time, resources are being cut. Staff education programs are often the first thing to go when budgets are cut, but this may be a "penny wise and pound foolish" move when it comes to patient access departments. After all, if staff are poorly trained, the hospital's bottom line likely will suffer, as claims denials increase and upfront collections decrease.

"Are formal staff education programs a luxury ripe for cutting when times get tough? I'm afraid so," says **Peter Kraus**, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta. "Changing, reducing, or eliminating a well run, productive program is bound to have a negative impact. You have to weigh your choices and go with the least of evils."

An additional negative is the effect that downsizing can have on meeting the standards for compliance with government entities and accrediting bodies. "Even the best processes can fall apart when we skimp on quality and rush though our work. When you think about what this could cost an organization, it is a big eye-opener," says **Katherine Murphy**, CHAM, director of access services for Nebo Systems, a subsidiary of Passport Health Communications in Oakbrook Terrace, IL. Murphy also is a delegate to the National Associate of Healthcare Access Management and the president of the Illinois Access Association.

Potential problems with downsizing include failure to obtain the Advanced Beneficiary Notice (ABN), incorrect or missing information on the ABN, violations of the Emergency Medical Treatment and Labor Act, violations of patient privacy regulations, missed opportunities with 1011 filing, and failure to obtain consent forms, warns Murphy.

So how are patient access leaders maintaining education of staff during the recession?

"Our hospital system has certainly not been immune to the current financial crisis," reports **Jessica Murphy**, CPAM, corporate director for patient access services at Methodist Le Bonheur Healthcare in Memphis, TN. "Ensuring the patient access salary expense budget falls in line with the 'leaner look' of 2009 has been accomplished, to a great extent, by eliminating unfilled positions."

The hospital's access directors have restructured existing jobs to accommodate a balancing of duties, days, and hours of coverage. Every task is carefully monitored, says Murphy, with a renewed interest in answering these two questions: "What is the added value in performing this task?" and "What does it cost in resources?"

"The only areas exempt from this intense scrutiny are those with a direct impact on quality and customer service," says Murphy.

Cross training is one answer

"Cross-training has always been a desirable work philosophy, but this year it will escalate to a necessary technique to manage the 'more with less' commitment," says Murphy.

Murphy says that her hospital is experiencing the nationally recognized impact of layoffs and loss of insurance. She reports that the number of ED patients is growing significantly, and that more patients are opting out of elective procedures and tests.

"Sending staff home due to 'lack of work' seems incongruous to the structure of a busy admission and registration department. Patient access is an area where there is *always* work to be done," says Murphy. "In reality, however, that is another way we are being asked to monitor and evaluate on a daily basis for optimal FTE ratios."

On a regular basis, the hospital's CEO is providing personal video updates, made available through the Methodist Le Bonheur Healthcare Intranet, to make sure all staff know how the organization is doing, from both a quality and fiscal perspective.

"This has had a very positive impact on morale and has kept rumors to a bare minimum. Staff attitudes are strong and supportive," says Murphy. "We are hearing on a regular basis, 'I am grateful to have a job and will do what is asked of me.' This often leads to creative thinking and process re-engineering that might not have happened in a more complacent environment."

The health care system operates with a centralized business office, headed by a corporate patient financial services director, health information management departments at each facility with dual reporting to a corporate health information management director, and patient access divisions at each facility with dual reporting to Murphy, the corporate patient access services director.

"All three of us report directly to the corporate CFO," says Murphy. "His expectation is that we pool resources and design a task around 'Where can it be efficiently provided?' not 'Where does it report?' on the organizational chart. In keeping

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Editorial Questions

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with that philosophy, we are designing a new approach to training and education this year."

The patient access department has had a dedicated trainer/educator for the past three years. This year, patient financial services was planning to post a position and hire its own dedicated trainer/educator.

"Our CFO asked if my trainer and I couldn't look at the possibility of taking that on instead of hiring for this new position," says Murphy. "It so happens that we have both been patient accounting directors in the past, as well as having many years of access knowledge and experience."

The two women met with the corporate director of patient financial services and have now begun designing a training agenda and calendar for the department's associates.

"This meant that we had to carefully assess our own calendar commitments, and reduce or eliminate those that do not absolutely require one or both of us to be part of that team," says Murphy.

As a result of this change, the training schedule for patient access was cut. While three-day classes previously were held each month, these now will be provided every other month. On the alternate month, three-day classes will be given to patient financial services instead.

"We are looking for training opportunities where access and patient financial services can attend the same class," adds Murphy.

Murphy says that this expansion of duties and knowledge has given her a better perspective for where access needs to concentrate its efforts from a quality perspective.

It also gives her the chance to explain to patient financial services account reps and collectors how registrars work and what challenges they face each day. "We think this is a win-win concept, with the added advantage of saving the company the cost of an educator position," says Murphy.

Although the advantage of a full-time trainer in patient access is lost, Murphy says that the change is a positive improvement, because it cultivates the "buddy system." "The two departments will now work even more closely as a team and will develop an increased respect for the challenges of each area," says Murphy.

Staff ready to learn something new

At Bon Secours Hampton Roads Health System in Portsmouth, VA, patient access recently lost four schedulers, which has made ensuring staff education and training more challenging, says **Dee Sutton**, manager of central scheduling and concierge services.

"In the past, there may have been a bit of a cushion — now you really have to be very creative," she says. "We have to constantly ask ourselves, 'What can we do to get this done efficiently and timely — and do it with a reduction in staff?'"

The situation has forced patient access staff to be very creative in finding ways to improve efficiencies. For example, preregistration and scheduling previously each made a separate phone call to the patient, but these calls are now combined into one.

"We knew it was something that we could do, but we weren't doing it. Basically, our mission was to get that customer off the phone as quickly as possible so we could schedule our next appointment," says Sutton. "Scheduling was focused on scheduling, and registration was focused on registration. But we are finding now that we need to cut that extra call down."

Staff were cross-trained, so that when they learn how to complete the scheduling form, they also learn how to do the pre-registration and identify whether that patient's insurance needs any follow up.

The recession and budget cuts that many patient access departments are struggling with, says Sutton, are "actually, an opportunity to grow your staff under maybe a negative set of circumstances, but you can turn that to a positive. We are building our staff so they have more knowledge underneath their belts. When you are not being forced to do that, you get comfortable."

The fact is that most patient access staff are "ready to grow and learn something new," says Sutton. "Even though they are feeling the pressure of having less staff, they are also willing to jump in."

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Strategies to increase your preauthorizations

One hundred percent of scheduled cases authorized — that is the goal set by Boston-based Massachusetts General Hospital's financial access unit.

"If we don't have an authorization and referral for anything that is scheduled, and if it's not going to be postponed until we do get the authorization, then it has to go through an escalation process," says department manager **Joe Ianelli**.

The department uses two primary tools to ensure prior authorizations are obtained: One is a "48 hours" list, and the other is a "bill hold."

The "bill hold" involves accounts that have been discharged but that still lack authorizations. "This is typical for emergency admissions, as insurance companies may request clinical documentation as they are working on their authorization process," says Ianelli. "Technically, we should have no elective accounts on the bill hold, as our standard is to ensure authorization before the visit takes place."

As for the "48 hours" list, "anything that's been in-house longer than two days without an authorization gets really close scrutiny," says Ianelli. "If it's an elective procedure — meaning scheduled — we really have to have the authorization all sewn up before the patient even gets in the door."

Typically, the delays involve patients admitted via the emergency department who haven't yet been authorized. If the authorization isn't obtained for whatever reason — the patient's physician booked the procedure late in the process, or there are difficulties with the insurance company — an escalation process is used. "We get the chief medical officer involved, and they have a discussion physician to physician about whether the case should move forward," says Ianelli.

However, most physicians "want to do the right thing financially and clinically for everyone involved," says Ianelli. "And if they can't justify the case as emergent, they will be amenable to postponing the procedure. We do take the clinical imperative as the priority. "

At North Shore-Long Island Jewish Health System, patient access has increased the percentage of times that staff secure authorization for scheduled hospital services from about 75% of the time to about 95% of the time.

"This has measurably reduced our denials and back-end rework, and has had a positive impact on our agings and cash flow," says **Frank Danza**, vice president of revenue cycle management "Equally as important, we have been able to isolate those scheduled cases where the payer is unwilling to provide an authorization for an inpatient level of care, before the patient receives the service."

This allows patient access staff to work with the doctor both before and on the day of service to make sure that he or she has documented the clinical rationale for the admission in the admitting order and related notes. "We expect to see a measurable decrease in inpatient denials and resulting downgrades to outpatient reimbursement levels during 2009," says Danza.

Financial rounds meeting is key

Massachusetts General's patient access staff attend a weekly "financial rounds" meeting every Wednesday at 10 am, to review the status of all outstanding authorizations. "This is something I've been doing every week since I got here seven years ago," says Ianelli.

Attending the meetings are a supervisor and two team leads in the insurance group, and two supervisors and one team leader in the financial counseling group, as well as all frontline staff. "We are one contiguous group, and we talk to each other a lot," says Ianelli. "We have SharePoint sites where we post policies and procedures so people don't have to have their own libraries — it's all right there for them."

Ianelli says that of the three major payers in Boston, two are now saying there could be significant changes in their authorization processes. The constant changes, he says, mean that "I need really smart, responsive staff."

The "financial rounds" meeting is based on the model of medical rounds done by physicians to discuss their patients as a group. "I do the same thing here financially. I want to know what's going on with cases that haven't been posted yet, that don't have authorization," says Ianelli. "We have literally everyone in the room, and I go around one by one."

First, Ianelli goes around the room to ask the insurance verifiers, "Who's on the 48-hour list that you haven't been able to post?

"And I want to hear the reasons why," he says.

The purpose isn't to intimidate staff or put anyone on the defensive — it's to solicit ideas to get to the bottom of how the authorization can be obtained. "If there is a tough motor vehicle accident and somebody isn't responding, somebody may say, 'Have you tried calling the police station?' or 'Maybe we should get legal involved,'" says Ianelli. "We try to use a team model approach to get the authorization."

Staff appreciate getting feedback on tough cases from other members of the team. "I think at first, the staff felt nervous going to a meeting like that, but over time they felt really supported," says Ianelli. "Everyone is in on the decision, and people who have been doing this for a long time can share their knowledge. We have been working this way for a very long time."

For each case, Ianelli hears from the financial counselors as to whether the patient is already admitted or is coming electively, and whether he or she is self-pay, a pending Medicaid authorization, or otherwise. "I want to hear where we stand on the process — is it a done deal? Do we need to postpone?" he says.

Financial counseling staff can help move the process along for the most difficult cases. "If my insurance verifiers are having a hard time because there are some insurance issues, then we can get financial counseling involved at the earliest possible stage, so that we can possibly help the patient to apply for public benefits or to set up payment plans," says Ianelli.

Denials are learning tool

Ianelli says that if a claim is denied, the insurance team supervisor, Ianelli's direct report, is the one who handles the appeals. "So when we mess up, we are responsible for trying to fix it," he says. "The clinical appeals are of course handled by case management, but the technical denials come right back to haunt us."

For this reason, Ianelli says that he tells staff, "'Deal with it now or it's going to be a ghost — it will come back to haunt you. So if it slides by and I don't hear about it, it's going to come back and it will be worse.'"

Denials are used as a learning mechanism. "We do 65,000 to 75,000 cases annually, and over 6,000 cases a month, with about 15 people, so it's a huge work volume," says Ianelli. "Sometimes, it's hard to get at the root cause of where the problems are."

The patient access supervisor has to figure out where the fault lies. For example, "Is Payer X acting differently? Did something change over at the payer or do we have a staff member who is making mistakes?"

"We certainly push back with the payers, and payers typically respond if they're at fault," says Ianelli. "We make sure to develop a case on why we should get paid. Sometimes, quite frankly, we have to fall on the sword and tell them that there was an error but we want to get paid anyway. They may say no, but it does happen."

With the large volume of cases handled by the department, it's inevitable that something will fall through the cracks occasionally. "A new staff member may miss the secondary payer, for example, or a coordination of benefit issue will happen from time to time," he says. "But as long as somebody is committed to being error-free, I think everything falls into place."

Ianelli says that when he first joined the organization, he needed to make a decision about the direction the department was going to go in. "We made a strategic decision to have some turnover to get the people in that could do what we needed them to do," he says.

Ianelli adds that unlike many patient access departments, his doesn't have issues with morale or turnover — something he attributes, in part, to the team model and supportive environment he fosters. "In terms of financial staff, we have a nice long period of stability for I'd say, about three years," he says. "If people are leaving, they tend to be wanting to stay in the industry and go to nursing school. We do have somebody right now who will go part-time and still work."

The department has not had to face budget or staffing cuts, reports Ianelli. "We are really lucky so far," he says. "We report right up through the CFO, and she has a good sense of what is needed down here. And on the flip side, if she does ask a department to cut its budget, she makes sure that her departments are cut equally."

Over the past seven years, volume has grown significantly at the organization, but Ianelli has only asked for one additional FTE. "We don't just try to throw bodies at a problem — we run pretty lean here in the financial counseling and insurance groups," he says.

Success, whether with obtaining 100% authorizations or improving registration accuracy, "all starts with the interview," says Ianelli. "If

you don't get good people in, everybody's going to end up miserable," he says. "Early in my career, I really hired badly and it's so much more work. And if you don't set the limit and get rid of people who aren't showing up and doing a good job, then you're not doing your job as a manager."

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Growing focus on ED collections: Here are tips

Obtaining copays and accurate insurance information in the emergency department is not easy — and, therefore, is often not done. The department is not only hectic, but the Emergency Medical Treatment and Labor Act (EMTALA) also presents obstacles unique to the ED.

However, ED collections are becoming more important to the hospital's bottom line — and patient access is being charged with revamping the collections process.

"There is a great opportunity for collections on the front end," says **Sandra N. Rivera**, RN, BSN, director of patient access at St. Joseph's Wayne Hospital/St. Joseph's Regional Medical Center. "Pushing collections to the front end allows for an increase in collections prior to the bill being generated and reduces the number of days for expected payment."

Rivera says that it's helpful to develop a process for staff to be able to view outstanding balances and let the patient know their responsibility.

Challenges are many

"The ED is a busy and oftentimes hectic place," says **Frank Danza**, vice president of revenue cycle management at North Shore-Long Island Jewish Health System. "Securing complete and accurate insurance information, collecting copays, and making sure that the patient understands their responsibility and their financial assistance options is not easy to complete in the time that an ED treat-and-release patient is in our facility."

For this reason, North Shore-Long Island Jewish's patient access staff is focusing on patients as they exit, as well as when they enter the process. Before the patient leaves the facility, patient access staff makes sure to cover these areas: reviewing personal information such as address and contact information, confirming insurance information, collecting copays, and reviewing financial assistance options for self-pay patients.

"While we have had modest staff increases to perform this function, we have achieved efficiency in the process by providing our staff the right education and tools to get their jobs done," says Danza.

According to **Suzanne Frank**, director of revenue cycle at Wheaton Franciscan Healthcare-Iowa, the three biggest challenges of ED collections are that they are not "patient friendly," they cannot be done at the point of entry, and physical barriers.

"Many EDs — including ours at Covenant Medical Center — are not set up in a conducive manner for collections," explains Frank. "We have multiple exits, making it difficult to capture patients at the point of departure."

Frank says that her department has done a lot over the last year to get copay collections and self-pay deposits upfront at Covenant Medical Center, largely focusing on staff training. "Our ED visits have continued to increase, as many hospitals are experiencing," says Frank.

Patient access staff attempt to collect the payment after the patient is treated in the ED. If patients express concern over their ability to pay, they are immediately referred to a financial advocate working in the same area for assistance.

ED collections are a frequent topic of discussion at staff meetings, with individual staff members discussing experiences and celebrating successes.

"We provide open discussion, scripting tools, and process flow tools to the associates," says Frank. "At this time, we're looking at both dollars and the number of collections to measure our efforts. Over the last few months, we've seen a steady increase in both measures due to the team's efforts in that area."

Care can't be delayed

"Collections in the emergency department must not delay any clinical care," says Rivera.

"Providing clinical care of the patient must be the No. 1 priority."

This ensures compliance with state and federal regulations, says Rivera, as well as the mission of the hospital.

"Once the patient has been medically screened and stable, some institutions may attempt to collect or notify the patient of their payment responsibility," says Rivera. "This can be challenging depending on the disposition, or lack of final disposition, of the patient."

Rivera says that the process of collecting after discharge appears to address EMTALA guidelines and avoid any collections from patients that are to be admitted. "Collections are based on the patient's commercial insurance cards, and are for treat-and-release patients."

Having a patient tracking tool or automated process to track these patients can greatly help your registration staff follow up on patients, once they have been discharged but before they leave the ED, adds Rivera.

If this is not available, a manual tracking process can be set up to flag the chart once the patient is ready for discharge, so that the registrar can follow up on the co-pay collections. "The support of the clinical staff is essential when you do not have an automated tracking process," says Rivera.

The floor plan or geographical set-up of the department also can present challenges regarding patients leaving prior to having financial clearance. "EDs with multiple exits can allow for this to occur," says Rivera. "The set-up of a financial discharge point can assist to resolve some of this issue or having a specific employee designated to this task."

Rivera recommends that before starting an ED collections process, you make sure to have these "nuts and bolts" in place: a petty cash drawer, a drop safe, and software or credit card equipment to enable this process. "Depending on your institution, you may need to issue numbered receipts to the patients and maintain a log that is reviewed by management and the cashier to maintain controls," she says. "Keeping track of your collections in a scorecard or report to monitor your progress is essential."

You will need to come up with a benchmark for expected collections. This can be achieved, says Rivera, by collecting a copy of the insurance cards in the ED and obtaining an average of possible collections from the information on the ED copay. "This varies from plan to plan and should only be used as a guideline," says Rivera.

Several years ago, the patient access department at Long Island College Hospital of Brooklyn dedicated an employee specifically to ED collections.

"She collected an average of $700 to $1,100 a month — not a lot of money, but at the same time, she was able to reach out to many of the patients, helping them apply for Medicaid and giving them other options to make payments to the hospital," says **Kathy Matthews**, director of admitting and ED registration. "It was considered a promising start."

After only two years, however, staff turnover and other issues caused the program to falter. "Now we are building a business office devoted to the ED, *in* the ED, which will become operational in the next few months," reports Matthews. "We hope this will improve collections by being a more professional, permanent fixture in the ED."

The person who previously handled ED collections was from the hospital's Medicaid office. When that single position was eliminated, collections lagged. "Now, however, under a new administration, the issue was revisited and even upgraded to business office status," says Matthews.

The new ED business office will tackle the following:

- copay collection;
- enrollment in Medicaid or charity care programs;
- booking follow-up clinic appointments;
- referrals to the hospital's network of primary care physicians, if the patient lacks one of his/her own;
- referrals to the hospital's specialists.

At Long Island College Hospital, admission from the ED comprises over three-quarters of inpatient volume. "So while treating the patient is important, the follow up while the patient is still in the ED is vital to future business," says Matthews. "In this way, we hope to maintain a connection to the patient and his or her future care, thus growing volume."

Most patients will pay

Once all care is rendered, Rivera says most patients *will* make the required payment. Those who are not able to are given a self-addressed envelope with a basic statement informing them of the copayment responsibility with the amount

listed. "You will be surprised how many patients do mail this back," says Rivera.

The implementation of collections in the ED requires careful process change, says Rivera, including "training, training, training of frontline staff." You will need to give your staff the necessary tools to be able to approach the patient with information, including scripts on how to handle different scenarios.

Rivera's staff attended a training class, developed in-house, that included scripts and role-playing. "One of the key elements in collections is letting the patient know, 'This is the co-payment as required by your insurance company or your insurance contract,'" says Rivera. "If they are still unsure, it is also clearly documented on the patient insurance card. Take the time to explain and show them the fine print on the insurance card."

Technology can greatly improve this process, "but do not let it be a show stopper," says Rivera. "This can be implemented and you can achieve collections without technology."

Once you have "made the leap" into collections on the front end, Rivera advises setting up an incentives program for staff on the highest collections days for the month. St. Joseph's staff collections are tracked on a monthly basis, by using data in the log book.

"We are an inner-city hospital where you have to work every other weekend," says Rivera. "We have given an additional weekend off as an incentive for completing the highest copays, or the prize can be a preferred parking space. Staff are receptive to this and have enjoyed the competition."

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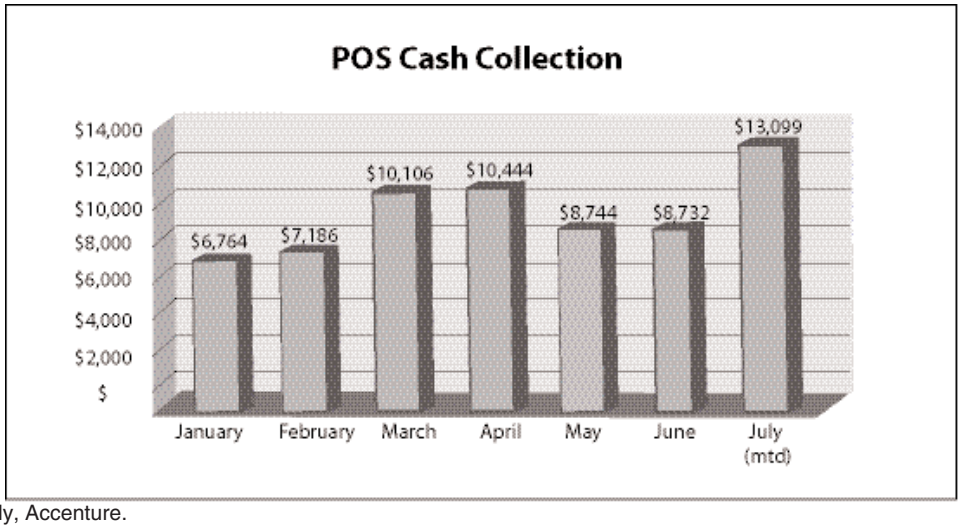
Use indicators to inspire 'friendly competition'

Editor's Note: This is the second of a two-part series on use of performance indicators in patient access. This month, we tell you how to use these data as tools to motivate staff. Last month, we covered ways to develop the most effective scorecards.

When staff productivity is tracked with indicators, a "friendly competition" often results, such as staff competing to see who has the most point-of-service collections.

"While many individuals in patient access are not initially comfortable with the collections process, when they begin seeing results within their teams as well as across the organization, they want to perform better," says **Jeff Roche**, a manager at Accenture's Lancaster, PA, office. Roche has worked with a number of hospitals to develop key performance indicators for patient access.

"They feel that they are providing a service that assists the hospital's bottom line, as well as



Source: John Woerly, Accenture.

helps to communicate a patient's liability for service in a more patient-centric method," says Roche.

Roche acknowledges that effective scorecards are sometimes difficult to implement, such as getting consensus on what to measure and how to measure it. "But the value that it provides — the ability to quickly demonstrate value and/or where problems may be — is huge."

Most organizations do not even have broad scorecards, let alone one specific to patient access. "So when one is finally developed, organizations are overwhelmed by the positive reaction and improvements made," says Roche. "Now all departments are held accountable to similar standards and performance metrics."

Show improvements over time

According to **John Woerly**, RHIA, CHAM, senior manager at Accenture in Indianapolis, key performance indicators are "an important ingredient in continuous performance improvement initiatives."

As such, information should be shared with key stakeholders, as well as staff, who can contribute to improvements, says Woerly.

"One of the best ways is to post graphs showing improvements over time," says Woerly.

Indicators also can be used to stretch performance and to motivate staff to reach new goals, by depicting improvements over a course of time. "The access management staff could motivate performance by setting strategic goals along the way. Then, celebrate accomplishments as they are met," says Woerly. "Celebrations could be anywhere from a pizza party, $5 gift card, letter of accommodation in the employee's HR file or a simple and much-appreciated thank you."

The sample point-of-service collections data (see page 44) for a satellite laboratory registration site, developed by Woerly, shows process improvements in January through April, but begs one to ask: "What happened in May and June?"

In this particular case, May and June saw a new computer system being installed, vacations, and staff turnover. "Having this data on hand and in a timely manner, allowed adjustments to be made to allow July to rebound into a positive month for collections," says Woerly. "It also provided some 'hindsight' knowledge — perhaps we should have over-staffed in May and June in preparation of a new system installation. Data are powerful, if used properly."

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Low-cost ways to thank staff for a job well done

Tell staff what they're doing right

"Staff morale is *always* an issue for hospital access professionals," says **Kathy Matthews**, director of admitting and ED registration at Long Island College Hospital of Brooklyn (NY). For this reason, Matthews says she takes great pains to "let staff know what they're doing right."

I truly believe that patient access professionals are paramount to the success of a medical center," says Matthews. "The people with whom I work are intelligent and diligent. Their primary focus is the care and dignity of the patient."

Here are some ways that Matthews rewards her staff:

- **A departmental e-mail distribution list was created.**

"Whenever a staff member receives a compliment, be it from a physician, a patient, or a nurse, we immediately post a congratulatory e-mail to the group," says Matthews. "Similarly, when we've had a rough week, we use the group list to acknowledge and thank staff for pulling together."

- **Meals are eaten together.**

"We've found that meals taken together create a convivial atmosphere, which contributes to team building," says Matthews. During the holidays, a 'pot luck' style is used, with everyone contributing a dish, and several times a year the managers sponsor either breakfast or dinner, depending on the shift, to thank staff.

- **A "wall of fame" was created for staff who have achieved "Employee of the Month"**

honors.

The plaques are located in the reception area so patients can see them.

• **Departmental managers do not hesitate to step in when necessary.**

"We've filled in as receptionists, bed controllers, and so on. It is important for staff to be aware of the fact that getting the job done is the most important thing," says Matthews. "At many other locations, this could create an issue with the union. That, however, has never been our experience, as they recognize that the good of the department exceeds all other considerations."

• **Important events in the employee's life are acknowledged.**

"We've found that when management acknowledges the life events that are meaningful to the employee, the work product is improved," says Matthews. "Accordingly, we make it a point to celebrate marriages, babies, citizenships, and other occasions. Rather than detracting from the work at hand, the brief time-out enhances our productivity."

Reward service excellence

According to **Angela Carson**, RHI, administrative director of revenue cycle management at North Central Baptist Hospital in San Antonio, TX, her department is committed to following the organization's "culture of service excellence."

"Based on this culture, our leaders are aware of how important it is to recognize and reward staff for their contributions to helping us meet our service excellence goals," says Carson. Here are some of the ways in which Carson recognizes her staff:

• Daily rounding is done by leadership to establish a personal connection with staff.

Carson asks staff specific questions, such as "What worked well today?" Is there anything you need to do your job better?"

• Thank-you notes are sent to a staff member's home, acknowledging a specific behavior or outcome that was observed by the team leader or a peer.

"These notes allow leadership to acknowledge staff successes in a personal manner," says Carson.

• Staff are given certificates that provide immediate acknowledgment of service excellence.

These can be used in the cafeteria, or can be saved and used for larger rewards such as caps, jackets, gift cards to area restaurants, or massages.

• A staff recognition program was created by one of Carson's departments, health information management.

The department purchased a "Trophy of Excellence," which is presented to a staff member who exemplifies service excellence. "This recognition is unique in that the person who is awarded the trophy gets to select who the next recipient is going to be," says Carson. "That person may or may not be a co-worker in his or her own department."

The idea is that each recipient will pass the trophy around the hospital as they recognize each other's successes. "As new recipients are identified, they are invited to the monthly department staff meeting and presented the trophy in front of their peers," says Carson. "Each new recipient's name is engraved onto the trophy."

Reward staff for these things

Carson shares this list of things that patient access staff could be rewarded for:

• participating in staff meetings and asking questions that perhaps the whole team wants the answer to, but no one wanted to ask;

• covering open shifts or weekends;

• leading educational sessions during staff meetings;

• participating in community service projects supported by the hospital, or other activities outside of work;

• attending all required educational and staff meetings;

• identifying new ways to do jobs more efficiently, resulting in cost-savings for the hospital;

• being proactive in identifying issues that might affect the department's productivity — for instance, noticing that a copy machine needs maintenance, closely monitoring supply levels, and watching computer queues to make sure information is crossing in a timely manner.

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Use online resources for better registration accuracy

At Hackensack (NJ) University Medical Center, patient access staff are taking steps to improve precertifications and registration accuracy by obtaining information electronically.

"Our goal is to use online means to verify insurance, benefits, and obtain precerts and authorization," says **Anne Goodwill Pritchett**, vice president of patient financial services.

Goals are established for each hospital or clinical service. For example, in 2008, the goal was to reduce precertification and eligibility-related denials by 20% by Dec. 31, 2008. This reduction was based on the cumulative amount as of Dec. 31, 2007.

"When patients schedule elective services online, during that process, not only do we capture the services that the patient is coming here for, but also the name and basic demographic information, including insurance and policy number," says Goodwill. From that scheduling system, staff are then able to preregister the patient and do a financial clearance. Insurance and benefits are verified electronically, using an online insurance verification process.

"Staff also have online access to most major payers to determine eligibility and benefits, says Goodwill Pritchett. In most instances, staff can key in the payer's name and patient's policy number and, within seconds, will get a response from the payer indicating that the insurance is active and what the copay or deductible are."

At that point, staff also can determine if that service requires an authorization. "We also can obtain the precertificiation of the authorization for many of the services online. For example, Aetna and Horizon Blue Cross and other payers have outsourced their precertification capabilities, and use a third party to provide precertification, and staff can key in the CPT code to obtain these authorizations.

"Before, you had to call to get that information. Now you can get it online," says Goodwill Pritchett. "The online process has significantly improved pre-certs turn around time."

Denials are tracked

Implementing the electronic remittance advice for most major payers has significantly improved the department's ability to track denials electronically by payer. "We are able to identify and resolve trends much sooner," says Goodwill Pritchett.

All new patient access employees attend a formal four-day training program before getting a system sign-on. The training covers how to utilize the system, regulatory and payers guidelines, and hands-on system training. "They get a lot of practice time in that four-day period, and after that, they go onto the floor," says Goodwill Pritchett.

Ongoing quality assurance is done, with performance analysts routinely checking the quality of work done by staff.

"Every day, we post our denials, sorted by payer and category of hospital service, so we can immediately tell if we have issues," says Goodwill Pritchett. "We look at how many accounts are denied because somebody did not obtain authorization for an MRI or imaging, for example. These sometimes are denied in error — the payer may have made a mistake."

This can be determined easily because the precertification data is on the billing record. "So it's very easy to determine who is responsible for the denial. If it is our error, and it happens that an error is made here and there, fine. But if it happens routinely by particular employees, we retrain them if necessary, and if continues, we follow the disciplinary process. We have very tight controls over denials because that impacts the bottom line."

Dynamic environment

Staff take great pains to keep up with the changing requirements of payers. "For Medicare, we go online several times a month, just to make

COMING IN FUTURE MONTHS

- The worst things to say to patient access staff
- What you absolutely should measure to assess your accuracy
- Foolproof ways to respond to complaints about your department
- Use data to show others your impact on the bottom line

sure we see any regulatory changes," says Goodwill Pritchett. If there are regulatory changes, these are printed out and reviewed.

On a monthly basis, Goodwill Pritchett reviews all of the new regulations, not just those that affect the billing department directly, but also anything that affects the organization. "At the end of the day, much of it *will* impact billing," she explains. "For example, if there is a change in the CPT code, where the payer used to allow three codes but now they allow only one, we then bring in the clinical service that is involved to be sure they are aware of it and that their charge screens have been updated."

Any changes made by managed care payers are obtained through the department's managed care director. In addition, the department brings in provider relations representatives of the payers onsite at least twice a year, to conduct training sessions for the registration staff and billing staff. "This is a chance for them to clarify any changes that have occurred and clear up any misinterpretations that our staff may have," says Goodwill Pritchett. "It is really very helpful."

The department also has its own internal trainers. If something needs to be put in a policy format, it is disseminated in an educational bulletin, such as major changes for a unique payer plan or product line. "If it's something very major, we will also have formal face-to-face training sessions," says Goodwill Pritchett. "This is a dynamic environment that is changing constantly. We recognize that in order to have an effective registration and billing staff, people have to be educated."

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