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Put the right data in your hands to stave off problems during recession

Make data your 'best friend'

Patient access departments are, without question, "under the microscope" in this recession. Managers need to prove their competency and show the impact of the department on the hospital's bottom line, while facing the threat of budget cuts that could reduce staffing, technology, and education resources.

Data just might be the answer to all of these challenges.

"Data can be the best friend to the patient access manager," says **Ed Erway**, chief revenue officer at University of Kentucky (UK) HealthCare in Lexington. "Of course, the department should always be operating in a cost-effective manner. However, leadership of the organization needs to understand the importance of access."

Data can demonstrate to leaders timely appointment scheduling, accurate pre-registration data collection including address and insurance verification, benefit determination, and pre-certification. "This ultimately leads to improved financial outcomes and improved customer satisfaction," says Erway.

"Lack of data makes the manager look unprofessional, like he or she doesn't know what's going on," says **Peter Kraus**, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta. "In terms of budget cuts, good data can't stop the inevitable when finances are really bad , but they never hurt. They can also prepare the 'powers that be' for eventual likely consequences, such as service disruptions, longer wait times, and less quality assurance monitoring."

According to Kraus, the most important set of data an access manager should have at hand has to do with the economic health of the institution. Does your hospital have a daily or weekly executive summary of key indicators, such as census, daily cash, daily revenue, and days in receivable? If so, you should receive this and be familiar with it, particularly with respect to the goals of the organization and how the goals of the access department affect them.

"This helps mold the image of the manager as a knowledgeable leader in the organization, not just the access department," says Kraus.

Next, you should know how your department is doing with respect to its own goals, be it number of registrations or wait times. "Finally, if there's a special project going on, or the manager's boss is focusing on a particular departmental activity, the manager should be conversant on all pertinent stats," says Kraus.

Here are some ways that patient access departments can use data to their advantage:

• You can show that access supports the hospital's clinical areas.

According to **Fairon F. Fitzhugh**, senior practice operations manager at Children's National Medical Center in Washington, DC, data can be used to reflect how the activities of patient access support the hospital's clinical areas.

Currently, the department is tracking returned mail — patient statements and letters to referring physicians and families returned by the Post Office for bad addresses. "Obviously, we're paying for postage; we want the mail to get to its destination," says Fitzhugh. "In these recessionary times, every penny and every referral matters. We're not getting paid if families don't receive statements, and our referring physicians need to hear from us about their patients or they'll stop referring."

Since physicians have complained about erroneous mailing addresses, these data are used to work with staff to improve their efforts in demographic information collection.

Missing charges are tracked for appointments that do not result in a charge in the billing system. "We use these data to ensure that every visit has a charge or, at least, an explanation why it isn't being charged," says Fitzhugh. "Often, this is because a charge ticket was not received by the staff. We use these data to go back to the physicians with the patient's name and date of service to get a completed charge ticket. "

• You can decrease claims denials.

Fitzhugh says that as her staff is responsible for obtaining insurance benefits and authorizations, data on denial information have been used to identify the need for additional intervention in certain areas.

"This then builds the case for why you need access staff," she says.

For example, the neuroscience clinic is home to neurology, the EEG/evoked response labs, and physical and occupational therapy. "Needless to say, pre-authorization requirements for these services have escalated fairly dramatically over the past few years," says Fitzhugh. "Denial data are used to justify the need for more FTEs."

Similarly, the urology division was receiving denials on circumcisions, not realizing that the services required authorization. "When we reviewed denial data, which include CPT codes and insurance carriers, we saw a problem," says Fitzhugh.

Access staff then contacted the insurance companies that were denying the claims to clarify referral and authorization requirements. "Once we understood what was needed, we were able

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Editorial Questions

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to stop those denials altogether," says Fitzhugh. "It's not always this easy, but this is a great example of how data can drive behavior."

• **You can make better business decisions.**

"We are reviewing appointment utilization to determine the viability of sending specialists to our different locations," says Fitzhugh. "We're finding that there is greater demand for some specialties at some of our locations than others."

The data are being used to recommend that some specialties reduce or discontinue service at one location and increase at another. This creates clinic space for specialties in higher demand, reducing the need to expand or take on additional lease expenses.

• **You can identify extended wait times.**

Fitzhugh says that her access department is currently using utilization data to help clinical areas identify problematic no-show rates (how many scheduled patients fail to show up for their appointments) and/or extended wait times for appointments.

"We have as an institutional goal a specific number of days in which we want new patients to be seen," says Fitzhugh.

Access tracks how long it takes to get a new patient appointment and no-show rates.

"When we look at how long it takes to get an appointment in the context of how many patients fail to show, the trend that is most often revealed: The longer it takes to be seen, the greater the likelihood of a high no-show rate," says Fitzhugh. "It becomes a vicious cycle; new patients can't be seen but we have clinics that aren't filled."

This has allowed some of the hospital's clinical areas to adjust their appointment slots to address long wait times, even on a short-term basis, to increase patient satisfaction, and decrease no-show rates.

• **You can measure customer satisfaction.**

When UK HealthCare's clinical departments updated their telephony systems, data were provided to the departments to show their abandonment rate, average speed to answer, and hold times. The data showed there was a wide variation in the departmental telephony metrics. Generally, those areas with low marks in the metrics also scored low in patient satisfaction.

"The goal is to effect improvements, leading to increased availability of appointments and customer satisfaction," says Erway. "The ability to measure customer satisfaction is crucial for success and not just using the traditional metrics."

Focus groups are used to evaluate current and new processes. "As we redesign our patient access model, establishing a call center, we will use the focus group to determine the impact on the patients and referring physician's reactions," says Erway. "We are interested in not only the first appointment we have with the patient but the subsequent visits as well. Long-term loyalty of our patients and referring physicians is important."

• **You can improve throughput.**

"Many of the newer emergency department systems now track time of a patient's initial check-in, triage evaluation, and the movement to a treatment room," notes Erway.

The systems also will track patients as they progress through the treatment process, including nurse assessment, physician evaluation, ancillary testing, treatment, and eventual discharge.

"These times can help a customer service representative assess and explain patient complaints about access when they occur," says Erway. UK tracks trends in patient arrival to rooms, boarder hours, patient diversions, and patients who leave without being seen.

"Also, the data in most institutions are aggregated to assist leadership in making process changes to improve patient access and throughput," says Erway.

At UK, these metrics are monitored by a patient throughput group consisting of physicians, ED, and hospital leadership. The group has initiated several projects to minimize patient boarder hours, diversions, and patient who leave without being seen. "Those are not only major points of patient dissatisfaction, but also have a negative impact on the financial operations," says Erway.

Must-have data

Erway says that data must be "retrievable, reportable, and easily understood" in order to effectively communicate the benefits of any access initiatives. He offers the below "must have" data for various patient access settings:

• **For a call center:** abandonment rate, average time to abandon, average speed to answer, average hold time, service level objective (the percentage of calls answered within a specific time period, usually seconds), and agent occupancy.

• **For an outpatient ambulatory setting:** next available appointment, no-show rate, patient bump rate six-12 weeks, patient bump rate < 6 weeks, new patient rate.

• **For a hospital setting:** average registration time, registration accuracy, number of registrations per shift per FTE, patient satisfaction with the registration process, co-pay collection rate.

Fitzhugh says that her department's "key indicators" data include no-show rates, wait times, time-of-service collections, eligibility denials, no authorization/no referral denials, template utilization, missing charges, and late charges.

"We use these data largely to refine what we're doing, what we already know is working, and could work better," says Fitzhugh. **(See next story on specific types of data that patient access departments can use to their advantage.)**

The department uses data to answer these questions: Are time-of-service collections low? Are we collecting deductibles? How do we prepare ourselves to know co-pay amounts? Do we have enough staff to obtain necessary authorizations? Do we know the insurer's requirements? Are we keeping up with carrier newsletters? Can we use online authorization?

Sharing data with staff has even given rise to competitions among some of the clinical areas, for which has the highest time-of-service collections or the fewest errors on different reports. "We have used data to educate and engage staff, clinicians, and leadership," says Fitzhugh. "Staff have gained a better understanding of how their work impacts our services, our families, and our physicians." ■

These data can have a powerful impact

Statistics can 'prove what you feel in your gut'

An ancillary department repeatedly insists that patient access staff are entering the wrong orders. If this accusation was made about your department, what would your response be?

In this case, a patient access manager used data to prove that the errors were a very rare occurrence, and one that was being blown out of proportion.

"When we actually drilled down to the details, we had an error rate of .02%, which is basically human error. The problem wasn't being viewed in terms of the total volume or scope of our responsibilities," says **Karen Veselsky**, CHAM, regional director of the revenue cycle at Catholic Health Initiatives in Exton, PA.

"By gathering those statistics, you can really prove your case. It really proves what you feel in your gut."

Without these data, however, Veselsky would have had no way to support her conviction that the mistakes were rare. "In all likelihood, we would have wound up changing major processes, and probably patient flow," she says.

Patient access did periodic monitoring of these errors once the base rate was established and then stopped monitoring it until the ancillary department said it was happening again. The error rate still was in the 0.2% or .03% range, proving again that it was just the ancillary department's perception. Here are some other valuable data to have:

• **How much cash is collected by staff at the point of service.**

"Obviously, whatever is collected by patient access, the back end doesn't have to collect," says Veselsky. "Costs are saved for postage, statements, and outsourcing to collection agencies."

Once you have established your cash collection goals, you can break these down to individual FTEs in your department, says Veselsky.

"In order to be very successful collecting point-of-service cash, you need to have a very strong preregistration and verification program, and have the software tools to be able to estimate what the patient's out-of-pocket expense is going to be," says Veselsky.

If you have all those components in place and you are a target of a reduction in the workforce, Veselsky says you can now say that, "If the expectation is, I collect X amount per month at the point of service and I have ten employees and you are going to take two away, that increases that point-of-service cash collection — not to mention the other work that goes with that — such as the preregistration and verification. You can ask, 'Now I need to spread that amongst eight employees. Is that achievable?'"

• **Data on your accuracy rates.**

You want to be sure that demographic information as well as insurance information is validated, so that the bill is sent to the appropriate payer the first time. "Any rework is very expensive," says Veselsky.

"There is the whole revenue cycle that can either win or lose, depending on whether that registration is accurate," says Veselsky. For example, a utilization reviewer in care management won't have the correct insurance carrier notified

for an inpatient admission, for authorization, or precertification, if it's registered incorrectly. Depending on the insurance, this mistake could result in a financial penalty for the hospital or, in the worst case, a total stay denial.

"If you have the incorrect demographics, statements can't be generated to the patient," says Veselsky. "Not to mention that, in most hospitals, the physicians rely on registration data for their billing. So this error doesn't just negatively affect the hospital, it negatively affects all the providers."

An impressive accuracy rate can change the perception of patient access in the organization. "If you've gotten a bad rap, so to speak, that 'The front end is always getting it wrong,' you've got to have those data available to say, 'That might have been true five years ago, but we've done a lot of education and training of our team members and now our accuracy rate is at 98%.'"

If you are measuring individual patient access team members against the volume of registrations to determine staffing levels, Veselsky says you need to take into account those functions of preregistration, verification, and financial counseling that go on behind the scenes as well.

To use the data to improve accuracy, you need to narrow them down to the team-member level and assess whether this is just human error or a pattern of behavior. If there is a consistent pattern of behavior where the team member doesn't understand how to register a specific insurance plan or may not be familiar with all the functionality of his or her HIS system, then education and training need to take place.

"Some facilities take it a step further and really monitor the claims that are being unbilled and for what reasons, and then equate them to dollars by registration team member," says Veselsky. "On any given day, a registrar would know, 'Because I made errors on ten accounts in the last three days, those errors are holding up $100,000 worth of billing.'"

This is powerful information to give to a team member, who might not necessarily correlate registration and billing, or fail to comprehend his or her role in the bigger picture of the revenue cycle.

• Data that correlate longevity in the department to accuracy.

"If you can show what a longer-term team member's accuracy rate is, compared to a new hire, you can then make the argument that we really need to sustain and maintain our employee base," says Veselsky.

"A lot of hospitals view patient access as an entry-level position, and it probably was 10 or 15 years ago," says Veselsky. "It really should not be viewed as an entry-level position any longer."

This is no longer fitting, says Veselsky, because patient access team members are expected to know about reimbursement, authorization, to be a collector of point-of-service cash, to educate patients about their rights and responsibilities, and even ask clinical questions such as "Are you allergic to latex?" at the point of registration.

"The closer correlation you can make for improved accuracy for long-term employees will help you justify a higher rate of pay," says Veselsky. "If I have a five-year team member who is at 98% accuracy consistently, and my new hires are at 75%, I really need to make sure that my turnover is minimal."

Veselsky says that the way to do that is to create career paths and ladders and provide leadership opportunities for those longer-term employees, to entice them to stay within patient access. "A lot of people leave patient access because they can make more money or work better hours in another department. And most other departments view patient access as a battleground — if you can be successful in patient access, we'll take you in the surgery department, or on another nursing unit." Your job is to give the team member a reason to stay in *your* department.

One approach that Veselsky says isn't effective is to have only two levels in your career ladder — the team member and the director or manager.

"That doesn't really provide a lot of opportunities for a team member," says Veselsky. "You can create either coordinator positions, where there is mentoring of new employees that can occur; and then, as you get into larger departments, creating managers that report to director, and providing education and certification opportunities."

The idea is to clearly show that decreased turnover will improve your accuracy rates, which is a big cost saver for organizations. "Recruitment costs can be pretty high, so as the retention numbers go up, there are cost-saving opportunities there," says Veselsky.

Veselsky says that sometimes when organizations look at cutting team members in patient access, it's done as a "knee jerk" reaction.

If cuts are related to volume, that makes sense, or if you are implementing a software tool that will make a process more efficient, it may be justification to cut an FTE, says Veselsky. "But a lot of times, senior leaders will make a 5% cut across the board," she says.

The problem is that as more consumers are left with high-deductible health plans, or no health plans because they have lost their jobs, more resources are needed in patient access and financial counseling. "Staff need to explain to these patients what their financial liability is or assist them with completing a financial assistance application, so that the hospital's financial integrity remains intact."

• **Data on your productivity volumes.**

This information can help you make a case for avoiding staff cuts, or if that's not possible, being upfront about how it will impact your department's productivity and the services you provide.

For example, you may know that on a given HIS system, a registrar who works eight-hour days should be able to generate X number of registrations. "If you can quantify that you are still going to see a given amount of patients, and you don't anticipate a volume decrease, you know that you will need a certain amount of staff to accomplish that job on a daily basis."

If staff are going to be cut, Veselsky says you should be "very upfront with your CFO or whoever you report to" about the services you will no longer be able to perform.

"You don't have any more hours in the day, you just have less people to accomplish the task," says Veselsky. "So you just have to sit down and say, 'I'm not getting any additional bodies to do this and I'm not reducing volume, so here is what I recommend we eliminate.'"

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Use data to deflect unfair complaints about access

Investigate fully before you act

When someone has a complaint about patient access — either an individual staff person or the department overall — how you respond can "make or break" what happens next.

"Good data can help deflect unfair or mistaken accusations made about patient access," says **Peter Kraus**, CHAM, CPAR, a business analyst with patient financial services at Emory University Hospital in Atlanta. For example, a patient may complain about a rude employee, but that individual doesn't work in patient access. A patient may say he or she waited an hour for service, but your data show that in fact, the patient waited an hour in radiology and only five minutes in access.

Data also can help you if an error is brought to your attention by someone in a department outside of patient access. "Responding that the registrar is 98% accurate overall comes across differently than just responding that an error was made and the staff member re-educated," 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*. "If other departments understand that the overall accuracy is being monitored, it demonstrates good proactive management."

The most common complaints about patient access involve incorrect data collection that causes the department in question more work. For example, if the registrar incorrectly identifies the physician in the system laboratory, radiology results will be directed to the incorrect provider. This causes the provider who receives the information to have to research and send it back to the hospital, and causes the ordering physician to not have the results timely, as the lab and radiology departments will have a hard time determining who the doctor should be.

"This is a common problem, especially when there are physicians with the same name — sometimes even same first and last name — practicing at the same facility," says Friedberg. "This is particularly common with foreign-born doctors that tend to shorten their names."

When responding to these types of complaints by other departments, data can establish the magnitude and validity of a given issue. "Other departments may feel that ten errors in a given month place an undue burden on them. But to patient access, ten errors is a minor problem," says Friedberg. "This is the type of disconnect that requires a lot of time and energy from the patient access director."

Don't go on the defensive

Friedberg says that patient access directors often have a knee-jerk reaction of trying to defend their staff in all circumstances. "I am not saying not to defend your staff when they are

attacked or in the right," says Friedberg. "However, a good way to defend them is to acknowledge a mistake, if in fact it was made, discuss the staff member's overall accuracy, and lay out the steps being taken to prevent the repetition of the mistake."

There often is a perception around a hospital that patient access is an easy job and that mistakes made are due to carelessness. This can put the access manager on the defensive from the onset. "If there are data to show that a particular staff member has a high accuracy rate, other managers are less likely to react in a negative manner," says Friedberg.

It is important to show that the number of errors of a particular type is small, such as duplicate medical record numbers, which are a burden on the health information management (HIM) department. Friedberg once was approached by his CFO about a high number of 75 duplicates in a given month, which the HIM director had complained about.

"My response was that we had started to notify HIM of errors so that records could be merged, and that 75 duplicates out of 15,000 registrations equated to a 0.5% error rate," he says.

Friedberg adds that in these difficult financial times, it's vital for patient access to create its own data, to identify potential problem areas internally *before* others bring them to the attention of higher-ups. "Providing discussion of efforts to reduce errors, based on proactive discovery of areas of deficit supported by data, is even more important," he says.

Investigate fully

"I never assume the registrar was wrong," says **Vicki Lyons**, patient access manager at Baptist Hospital East in Louisville, KY. The hospital's patients relations department follows up on most complaints, but if it is unsure of the exact process that should have been followed, Lyons is asked whether the registrar did or said the wrong thing.

Lyons says that if in fact the registrar didn't do anything wrong, you can use that as an opportunity to inform the patient about how the hospital registration process works.

"If I need additional information to see exactly what the complaint is, I will call to ask more questions," says Lyons. "If the patient relations department and I talk, and they know exactly what the issue was, then they will make the phone call back to the patient." At times, though, patients do not want a phone call back — they just want to know that someone will look into the process and follow up.

"The worst thing you can do is not follow up on a complaint. I think it sends the wrong message to the person making the complaint — that someone does not care enough to make a phone call back," says Lyons.

Lyons always tells patients that she's sorry for any inconvenience that may have been caused by the incident, and that they can feel assured that the complaint will be taken seriously and followed up on.

In some cases, however, the patient's complaint may have been the result of another department's actions. In this case, Lyons tells the person complaining that she will notify that manager so that they can follow up with their employee or she gives the person the option to call the manager directly.

Lyons says that she doesn't use any scripting to address patient complaints. "Each situation and complaint is different. It sometimes sounds phony when a script is stated to the customer or patient."

Take these steps

Janice M. Grey, interim manager of patient registration services for California and Davies campuses at California Pacific Medical Center in San Francisco, says that the very first thing you should do is apologize for not meeting the patient's expectations. Next, thank the patient for bringing this issue to your attention.

Then, you should research the complaint fully and respond back to the patient with your findings, including any actions taken to prevent the occurrence from happening again.

"Don't minimize or dismiss a complaint, regardless of how minor it seems to you," says Grey. "We are dealing with the patient's perception of what occurred. If they are complaining, it is important to them."

For example, a patient may complain to you about having to wait to register for a diagnostic test, when the wait time was only about five minutes. Would you think that this complaint was baseless?

"In several of my high-volume areas, we see 350-400 patients a day," says Grey. "Our goal is to register 90% of all patients within ten minutes. So if the complaint came from that area, I might think it was not worth my time to investigate."

As it turned out, however, the patient did have reason to complain. "It was a rare slow time in that area and two staff members were chatting amongst themselves," says Grey. "That is the reason the patient had to wait."

On the other hand, don't make any promises to a patient before you research the complaint fully. "When someone is angry, they often stretch the truth just a bit in the heat of the moment when relaying what has taken place," says Grey. "Once in a while, you get someone that is so out of control and wants action taken against someone immediately for the wrong they feel has been done to them."

This may be happening in a public area, with the patient loudly demanding that the person receive disciplinary action or get fired.

"It is not easy being on the receiving end of this, especially in a professional setting," says Grey. "Your first reaction is to promise anything just to quiet the patient down and get them away from other patients. But more often than not, after researching the situation, you may find that it was not as serious an incident as reported, and minor or no disciplinary action is called for."

You may find useful information

In some cases, your research may reveal that something important needs to be addressed, such as a process that needs to be changed. "Good data can also lend credibility to resolution proposals when the complaint is valid," says Kraus.

For example, a patient once told Grey that the registrar made a mistake because all her physicians did not receive results of the diagnostic test she had completed. This, the patient explained, caused a delay in the treatment she needed. Grey retrieved the documentation that the staff person had at the time of the registration, including the physician's orders, and compared it against the account that was set up for the patient to see if it was done correctly.

"In this case, the registrar did not make an error. The physician listed on the patient's complaint was not on the requisition," says Grey. "When I shared my findings with the patient, she thanked me for bringing this to her attention. Her understanding was her oncologist was including both of her other physicians in all test results."

To prevent this from happening again, patient access staff now inform patients that only the physician listed on the requisition will receive their results. "If they need any other physicians to receive the results, we tell them to please let the ordering physician's office know, so they can forward them," says Grey.

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Does turnover keep you up at night? Try these tips

Do you want to discourage staff, send a registrar's morale plummeting, and as a result, deal with higher turnover in your department? If not, don't make these morale-busting mistakes:

- **Failing to say a simple thank you.**

"Staff want to be recognized. Oftentimes, a simple thank you goes a long way," says **Holly Hiryak**, MNSc, RN, CHAM, director of hospital admissions/access services at the University of Arkansas for Medical Sciences in Little Rock.

What you're thanking staff for doesn't have to be anything earth-shattering. You can thank an employee for offering to help out a co-worker who is busy or having problems with a task, working additional hours when needed, or adjusting his or her shift to accommodate department needs. "Compliment them on their smile or say, 'Thank you for smiling,'" suggests Hiryak. "This helps them remember to smile."

• **Failing to remember special dates.**

At SSM Health Care in St. Louis, the patient access department created its own registration newsletter that recognizes birthdays and anniversaries of employees, among other things. "Staff appreciation and recognition helps keep morale up," says **Jayne Wright**, patient access director of the organization's North Operating Group. "Having a strong support system does, too."

"It is important that you recognize days that are important to your staff, such as birthdays or anniversary dates," says Hiryak. "I also send Christmas cards to their home. It's about recognizing them as being a person and giving them respect."

Hiryak sends cards to employees on their birthdays and also sends a "thank you for being on our team" certificate to their home to recognize their anniversary date.

To remember these dates, Hiryak relies on the hospital's HR system, from which she runs monthly reports. Her administrative assistant prints out a list of birthdays and anniversaries, and Hiryak addresses and signs the cards. Also, a monthly birthday flyer is printed and posted, so everyone knows who is celebrating a birthday.

Sherri Pitkin, associate director of patient access management at University of Iowa Hospitals & Clinics in Iowa City, says that "the pre-access people have a monthly birthday treat day and a wonderful bragging board. Each person has a brief bio with their picture."

One employee is spotlighted each month with that person's choice of picture, such as his or her family or a wedding photo, hung on a large poster board by the "bragging wall." Co-workers are invited to comment and write on the board.

"For a call center, it has turned out to be a great way to get to know people even when the time to socialize is so short," says Pitkin.

• **Focusing only on the negative.**

"I have found, in my many years, to praise, praise, praise what they do right," says Wright. "With the thousands and thousands of registrations that they do every day, they get blamed for almost everything that can go wrong. Because we are the first step in the revenue cycle, we impact almost everything."

Provide a minimum of monthly, preferably weekly, feedback to every staff member, recommends Pitkin.

It doesn't matter if the staff member is a low or high performer, says Pitkin. "They all need face-to-face time with their supervisor or manager. This takes a very few minutes."

Pitkin recommends being "brutally honest" if there are deficiencies. It's not enough, however, just to tell someone to improve; you need to provide a personalized action plan for this employee.

"Observe the employee's workflow. Use a checklist of duties to find the staff's comfort zone and those areas where they are unsure," says Pitkin. "Most employees know their own weaknesses. If approached positively, they will become a driving force in their own improvement."

When coaching employees on how to improve, Pitkin says to focus on the effect they have on the patients. "Impose solid deadlines for the improvements. Follow through, and celebrate every accomplishment," says Pitkin.

Front-end staff need to know how they affect the entire revenue cycle and the individual patient, so "give the whole story in small bits," says Pitkin. "Explain that improvement in denials, cash collections, and satisfied patients are the end result of their work."

A staff committee allows employees to bring forth their own issues to management, either anonymously or as part of a group. "Staff need to be heard," says Pitkin. "The committee reviews the problem to make sure it really is an issue and helps the person come up with expected outcomes and viable solutions."

"Never reprimand staff in front of their peers," says Hiryak. "If someone is underperforming, we do work with them to point out where they could improve. But it is important to note where they are doing well."

For example, a staff person's accuracy may not be where you want it, but when you point this out to the employee, don't forget to mention his or her great customer service skills. "We would coach and council the staff on accuracy, *and* recognize those customer service qualities," says Hiryak.

• **Giving your best performers a heavier workload**.

Keep staff workload as even as possible by tracking the productivity and quality of individual staff members, advises Pitkin.

"Good performers will often get *more* work. I have seen this happen all too often, and this can be a morale buster as well," says Hiryak.

For employees who exceed Hiryak's expectations, she makes a point of thanking them publicly, in front of their peers. "This lifts everyone's

spirits," says Hiryak. "It gives those not performing well an opportunity to see the positive recognition that they can work toward."

• **Ignoring issues brought to your attention**.

Pitkin says that both good and bad performers must be addressed by patient access managers. Whether it is a staff person featured on the "bragging wall" or a complaint raised by the staff committee, both must be paid attention. "Issues brought up and ignored causes lower morale and resentment," says Pitkin. "Give an answer on each and every issue, even if the answer is no."

Pitkin says that timing also is an issue. "Address all issues quickly and follow through to make sure that the outcome is as expected," says Pitkin. "Seemingly small issues corrected quickly really boost morale, gain the employee's trust, and just make you feel good."

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Will workflow technology solve your problems?

Although workflow management is not a new phenomena in the business world, it is relatively new in revenue cycle operations, especially in patient access operations, says **John Woerly**, RHIA, CHAM, senior manager at Accenture in Indianapolis.

If you are looking at implementing workflow technology, Woerly says that one big hurdle is how you will quantify how such a system, which is typically very costly, will pay for itself in two or three years.

Also, Woerly says it's not always easy to determine where to best use workflow management or design a leading practice process flow, which is "not necessarily the one that you've always used." Another challenge is to provide the resources to implement and, even further, maintain the system and the rules that drive the automated processes.

No step is omitted or delayed

Businesses typically seek workflow management technologies to increase profitability and enhance competency. "Primarily, they hope that the use of such technologies will streamline and automate their transaction flows, better manage exceptions, and identify non-value-added activities," Woerly says.

Workflow management technology supports routing information of any type according to user-defined business rules, allowing information to be routed to one location or multiple locations, either simultaneously or sequentially.

Within patient access, this tool would allow you to move data from patient scheduling to financial clearance (pre-registration, insurance eligibility/benefit verification, pre-certification/authorization, referral management, and patient liability estimation and collection) and from financial clearance to registration/check-in and/or financial counseling.

Woerly explains that workflow concerns the automation of procedures where documents, information, or tasks are passed between participants according to a defined set of rules to achieve, or contribute to, an overall business goal.

"Much has been written over the years of a 'closed loop' process within revenue cycle operations," says Woerly.

Workflow management allows revenue cycle departments (patient access, health information management, case management, and patient accounting) to automate each step of their process flow in order to ensure that no step is omitted or delayed.

"It also allows process steps to be performed sequentially or simultaneously. This allows several people to work on segments of a patient's account, as an example, at the same time," says Woerly.

If properly designed and deployed, workflow management should have a substantial impact upon the reduction of account receivable days, as well as positively impact customer satisfaction and service.

Woerly says that an example he personally experienced was making an outpatient appointment with his provider hospital for three days out and within only a few hours, receiving a call from the financial clearance staff to be pre-registered.

"Workflow assisted my information to quickly travel from my physician's office to the hospital for the appointment, and then to the financial clearance area, to be alerted that I needed to be pre-registered and have other pre-service activities conducted," he says. "To say the least, I was impressed with the efficiency of the operation."

Woerly gives these tips for making the switch to workflow technology:

- Know your needs. "Define your key objectives and projected outcomes," says Woerly.
- Develop a project charter. This may include scope, assumptions, implementation issues and risks, organizational impact, critical performance indicators, milestones/timelines, key participants, and deliverables.
- Provide and enable the resources to plan, design, test and implement the system. "Don't underestimate the time and knowledge required," says Woerly.
- Get user involvement and buy-in, including all key upstream and downstream stakeholders.
- Create workflows to document each process step and hand-offs.
- Remember that the system is capable of change via rule updates. "Your initial process flows should assist you in defining data needs and flows," says Woerly. "However, as you progress, it is expected that updates will occur."
- Implement the new system in a pilot site before taking it across all processes or all departments.

"Look to see where the greatest opportunity in data flow exists," says Woerly. "Typically, in a patient access environment, it is the flow of information from patient scheduling, which many times is decentralized to multiple ancillary departments, to financial clearance."

- Provide a feedback loop for issue identification and resolution.

This should ensure that the workflow rules are set up properly and that timing and sorting of information is correct to allow the right people to get the right information at the right time.

Data on turnaround time, number of cases processed, number of cases held, and number of cases referred will assist you in improving work processes. "Statistics that are typically derived from workflow management tools will provide you with the data needed to improve the process," says Woerly. "But, it is essential that you use this information to drive process improvements and to provide feedback to all key stakeholders in an effort to inform and educate."

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Do 'complete re-education' on Medicare requirements

Joan S. Braveman, director of patient access and financial services at Tallahassee (FL) Memorial HealthCare, says that her department is in the process of doing "complete re-education" on the Medicare Secondary Payer questionnaire.

"Our insurance verification team will do a random review of the responses that are stored online in our ADT system," she reports. "They will be looking specifically at retirement dates, accident information, and spouse information." The random review will be used to give feedback and identify educational opportunities.

Braveman says that "the cause for the re-education is Medicare's Secondary Payer recovery contractors, rather than problems with the questionnaire itself." The questionnaire is built into the department's patient processing and accounting system. When a Medicare patient is regis-

tered, it automatically takes the registrar to the questionnaire and pre-populates some of the fields.

"With Medicare now making a much more concerted effort to ensure they are truly primary and actually doing recoveries on old accounts where they were secondary, I felt it important that my comfort level be high in regard to the colleagues' understanding and compliance, with compliance being the key," says Braveman.

Braveman says there are three scenarios that present big challenges:

• **Receiving a patient who is non-responsive.** "Obviously, we cannot ask the patient the questions, but we do look at previous responses on previous questionnaires, as well as the eligibility response, which would show if there is another payer, employment information, and retirement information," says Braveman.

• **When patient access staff do not see the patient.** "We have a large reference lab that processes specimens for which we bill," says Braveman. "Since they do not see the patient, only the specimen, we have to ensure that someone has reviewed all of the information available."

• **When a patient was in an auto accident in the past and now is receiving services for something unrelated.** "Unless we catch these on the front end, we will receive a denial," says Braveman. "We have set up a process whereby the insurance verifier contacts the Medicare billing team so they can bill appropriately. We also ask the patient to contact Medicare to get the file updated."

The education will be provided by the department educator as well as department managers. "Being a 24/7 operation, we have to do some creative scheduling," says Braveman. "We are also looking at educating our patient financial services colleagues. Although they do not interview patients and complete the questionnaire, they do have responsibility for ensuring coordination of benefits." ■