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IN THIS ISSUE

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Is a patient eligible for financial help? The sooner you find out, the better

There may be little motivation to cooperate

The patient standing in front of you, or on the receiving end of a phone call from an access staff member, may be confronted with a balance that he or she cannot possibly pay. What happens next?

"With the onset of higher-deductible insurance plans and health reimbursement account-type insurance plans, patients are finding that they owe higher amounts out of pocket," says **Jeff Brossard**, CHAM, patient access manager at St. John's Hospital in Springfield, MO. "Often, patients are unable to pay these out-of-pocket amounts due. In more recent months, this trend has become increasingly apparent."

For this reason, your process for determining if patients are eligible for charity or public programs has become increasingly important. Patient access' immediate concern is the ability to make contact with these patients prior to their visit. "From an outpatient perspective, it is better to contact the patient as early in the process as possible, preferably prior to the date of service," says Brossard. "This can pose additional problems, though, as some people will cancel their test or procedure when they find out about the high co-payment or deductible owed."

For inpatient services, St. John's Hospital contracts with an outside vendor for Medicaid eligibility screening. "If the patient does not qualify for Medicaid, they are then referred to our in-house financial counselors," says Brossard. "In cases where the patient has been discharged prior to the Medicaid screening completion, additional contact can be difficult."

Many negative impacts

Regarding eligibility screening, "It is better for both the health care facility *and* the patient to initiate this process as early possible," says Brossard. "The negative impact of not initiating this process early is the simple fact that facilities can miss the opportunity to help a patient obtain assistance. With this, the outstanding balance may go unpaid.

Expenses associated with collecting will increase."

Holly Hiryak, RN, CHAM, director of hospital admissions and access services at University Hospital of Arkansas in Little Rock, says, "If we miss the opportunity at the very first encounter, our work becomes more difficult, especially if the patient received the services they were seeking. They have little motivation to cooperate."

If a patient's self-pay status isn't identified early in the process, "the impact is twofold," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital.

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Editorial Questions

Call **Jill Robbins** at (404) 262-5557

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

"First, the need to have the discussion the day before a procedure causes undue apprehension for the patient and family, not to mention the staff member," says Pallozzi. "Second, obviously, the facility is in jeopardy of not being paid, especially for those urgent procedures that could have had a bit more notice provided to patient access."

One challenge is ensuring that patient access is notified of the self-pay status for patients with scheduled ancillary services. "We do not have a centralized scheduling system, which means patient access relies on the ancillary department to alert us of a self-pay patient," says Pallozzi.

Pallozzi says that "the name of the game is education and communication. With our system limitation, it is most important that the ancillary department managers are well versed in making the referral to our patient assistance unit. If we find a circumstance where communication was lacking, it provides the opportunity to educate the respective department or physician's office."

Another challenge involves balancing the patient care aspect with the financial aspect. "We never delay an urgent or emergent procedure, but we do postpone those services deemed elective," says Pallozzi. "If there is any question regarding the status of urgency, our medical director will assist in a conversation with the attending physician."

Albany Medical Center has a self-pay policy and procedure that outlines the expectations and escalation process of a case that may be in question regarding its status of urgency. The policy provides for the escalation process to include the medical director if there is a need for a physician-to-physician discussion for the patient to proceed. "It is a good source document for education," says Pallozzi.

Staff must know the basics

Brossard says that his access department has made a major push in education, to address the increase in self-pay patients. "Frontline co-workers are more often required to wear dual hats, so to speak," he says. "Not only do they need to be well versed in the insurance industry, but they must also understand the basics of financial counseling."

At St. John's, patient access staff use scripting to ensure that a consistent message is provided. New co-workers receive two weeks of classroom training covering all aspects of patient access. Several sessions on point-of-service collections, determining patient financial responsibility, and scripting for financial counseling referrals are included in this training. Additionally, the

department offers ongoing refresher training as well as annual competency training on all of these topics.

"The role of the financial counselor is expanding. Many health care facilities are creating additional financial counselor roles to accommodate the influx," says Brossard. "Also, depending on the cost of a patient bill, it is becoming more commonplace to provide assistance in the form of paying COBRA or Medicaid premiums, to ensure there is no lapse in coverage."

Hiryak says that one of her current challenges is to train staff to understand the various categories of Medicaid in the state.

"The process of determining the appropriate category and casework requires a tremendous amount of education," says Hiryak. "We estimate that it takes at least two years to train a caseworker to the point that second-party reviews are no longer required. It is a bit less for the applications specialists, but they are always in learning mode as policy changes."

To address this, a series of questions was developed to screen out individuals who do not qualify for assistance. Then, the applications specialist determines the potential category and takes the appropriate application.

Once the application is completed and registered with the state Medicaid program, the applications are sent to the Medicaid caseworker's department for completion.

"We have two staff designated for verification and home visits if needed and a runner, as we often have to hand-deliver some cases to our county offices," says Hiryak. "We have nine caseworkers, with three off-site and the remainder hospital-based." Once they complete the case, it is sent to one of the hospital's Department of Health and Human Services partners, who then keys the information into the database.

"We have actually aligned our applications specialist with the admissions/registration department," says Hiryak. "This enhances the work flow processes and prevents multiple unnecessary contacts with the patient." All patients classified as self-pay are picked up by the applications specialist. "They screen and/or apply for the patients. If any additional paperwork is required, they can get that completed while they are at the bedside," says Hiryak.

[For more information, contact:

***Jeff Brossard**, CHAM, Patient Access Manager, St. John's Hospital, 1235 E. Cherokee, Springfield, MO 65804. Phone: (417) 820-9089. Fax: (417) 820-4880. E-mail: Jeffrey.Brossard@Mercy.Net.*

***Holly Hiryak**, MNSc, RN, CHAM, Director, Hospital Admissions/Access Services, University of Arkansas Medical Sciences, 4301 W. Markham, Little Rock, AR 72205. Phone: (501) 686-8170. Fax: (501) 603-1243. E-mail: HiryakHollyM@uams.edu.*

***Catherine M. Pallozzi**, CHAM, CCS, Director, Patient Access, Albany (NY) Medical Center Hospital. Phone: (518) 262-3644. Fax: (518) 262-8206. E-mail: PallozC@mail.amc.edu.]* ■

Make staff accountable for registration accuracy

Have employees fix their mistakes

Without staff involvement in registration accuracy, no matter what a manager does, needless errors will occur. "Staff involvement provides a feeling of ownership and empowerment," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center. "It becomes an inclusive process, as opposed to a 'top down' environment."

Currently, Albany Medical Center's patient access department lacks an automated quality assurance (QA)/monitoring application. "We do, however, have a dedicated quality and development team," says Pallozzi.

The organization uses set guidelines for monitoring the accuracy rates of staff. All new team members are monitored at 100% for a period of time. Staff members achieving 95% for a three-month period are not monitored as frequently.

Pallozzi says her greatest challenge is that the four-member quality and development team also covers the organization's registration fundamentals program, customer service, and medical terminology, among other skill enhancement programs. "So if a priority needs to be bumped due to an identified need or staffing, it usually is monitoring," says Pallozzi.

Recently, a new "unit observation" initiative was implemented. A trainer is assigned to be in a unit for a day or two for the sole purpose of answering questions from staff during day-to-day operations.

"It is not done for the purpose of monitoring. It is an informal time with the quality and development staff member," says Pallozzi. "It has been a

great success, and we have gotten some wonderful feedback from the frontline staff. Staff have asked, 'When are you coming back?,' which is a telltale sign of success."

This concept has strengthened the relationship of the quality and development team and staff. "The quality and development team is being embraced as helpful, as opposed to being seen as the group that 'dings' me for an error," says Pallozzi.

Staff clean up own edits

Currently, **Pam Stevens**, director of patient registration at Cook Children's Medical Center, has a team of two people who manually do QA for about 95% of registrations. "I think this is the reason the back end is so successful," she says. "Patient financial services wouldn't drop nearly as many clean claims if we didn't do that work. My department is about 97% accurate, which means clean claims are dropping."

Stevens says that the department is implementing a new electronic system for registration QA that "will have scrubbers on it for billing edits. It will send a note to the person who actually did the registration, so they can clean up their own edits."

Stevens says that this will allow her to do more of the facility's QA, not just those who report to patient access but anybody in the hospital system who is doing registration. "That is something that the medical center will benefit from," she says.

Cook Children's has had an incentive program in place for several years, tied to accuracy and collections. Each month, a point-of-service collection goal is set, based on the prior month's revenues. "If staff are not at least at 95% accuracy for their QA, they are not eligible for incentives," says Stevens. "Probably nine out of 10 months, we make our incentive goal."

Teresa R. Drakeford, CHAA, CHAM, manager of patient access services at Carilion Clinic in Bedford, VA, says that one problem she contended with was determining who actually *made* the error. "With the current ADT system that we are using, anyone that touches the account or makes one change to it has their initials on it," she says. "We implemented charging anyone that has their initials on that account with the error."

For example, if the Medicare as Secondary Payer questions state a retirement date, but the registrar put the subscriber as unemployed, this needs to be corrected to reflect the patient's retired status. "We know this error will get fixed due to anyone touching the account being charged with the error," says Drakeford.

Six staff members check errors daily, including Drakeford and her team leader. "We send the employee what the error was via a communications function within the system, and we give them three days to fix it. If the employee does not fix it, it is counted against them," says Drakeford. "When they do not meet quality standards, they are not eligible for incentives for their upfront collections."

A board posts the name of the person with the best accuracy rate for the month. "Typically, when someone has their name on the board the most times, they receive a little gift," says Drakeford.

Give feedback

At Albany Medical Center, patient access staff receive feedback in written format. Occasionally, the trainer, unit manager or unit staff lead reviews this one on one with the staff member.

In addition, the department's quality improvement team (QIT) comprises staff lead, managers, and quality and development. "This is a peer program," says Pallozzi. "Through the formal monitoring program, areas that require some additional training are identified."

As for areas identified, Pallozzi says that "address format to ensure no mail return has been high on the list." Other areas include ensuring that a P.O. box vs. a street address are noted appropriately, as the system is sensitive to punctuation. "In addition, the team has created a mechanism for staff to conduct self quality checks of their registration," says Pallozzi.

After QIT members meet with staff individually or in small groups, the information is shared with the team. Results of the training are shared at the bi-monthly QIT meeting.

"Some staff have concerns with being monitored or 'graded.' That has been somewhat of a challenge. But I feel if the results of the monitor are shared in a respectful way — a perspective of 'I want to help you' — then the result is very positive," says Pallozzi.

Pallozzi adds that the same staff members who were unhappy about being monitored have had great pride when they actually see how they've improved. "They have a real sense of accomplishment," she says.

[For more information, contact:

***Teresa R. Drakeford**, CHAA, CHAM, Manager, Patient Access Services, Carilion Clinic, 2017 South Jefferson Street, Bedford, VA 24011. Phone: (540) 587-3258. Fax: (540) 587-0494. E-mail: tdrakeford@carilion.com.]* ■

Keep current requirements front and center for staff

Make your expectations clear

At Methodist Le Bonheur Healthcare in Memphis, TN, a variety of tools are used to keep current requirements "front and center" for scheduling, registration, and verification staff.

"At the heart of most of these methods is a strong communication link," says **Jessica Murphy**, corporate director of patient access services. "As much as possible, we tie competency, quality, and compliance expectations to a clearly defined key performance indicator goal for patient access."

These key performance indicator numbers are reported monthly and year-to-date to senior leadership, access management, and CFOs at each Methodist facility. "This has proved to be an excellent accountability incentive," says Murphy.

At Methodist LeBonheur, patient access is structured within a very small corporate office that sets policy and procedure for the system. This allows one area or person to funnel information to the access management team at each facility or free-standing center. Here are some of the tools used for that purpose:

• Monthly two-hour conference calls are held over a brown-bag lunch. "As the corporate director, I facilitate those calls," says Murphy. "Participation is excellent, and feedback is very positive."

• Once every four months, Murphy facilitates a full-day, off-site retreat. Included in the agenda are all-new or future policies, procedural updates, and key performance indicators report reviews. Each facility team is asked to cover issues, concerns, and best practices for their area.

"This facilitates almost instant benchmarking and networking," says Murphy. "Often, I will ask another department to send a representative to talk to us about how we can be an effective partner to them. I ask them to tell us, in general, what their department does and what they depend on from us." Some examples would be patient financial services, health information management, case management, credit, and collections.

"We have an access director who volunteers her home to us for the day," says Murphy. "From my corporate budget, I furnish a main entrée for lunch, and all the participants bring a side-dish for pot luck. This keeps costs to a minimum."

• A patient access services web page is maintained with policies, procedures, definitions, forms, contact lists, and links to other departmental web pages that would be helpful to patient access.

• E-mail is "used as effectively and judiciously as possible," says Murphy. "Address groups allow for wide distribution or can be directed to management only. Often if we see a pattern developing from a denial perspective, we attach an 'alert' notice describing the problem and delineating the correct process," says Murphy. "We ask that it be distributed to all patient access services workstations and staff."

• Important documents or notices are mailed to the homes of supplemental PRN staff or anyone on extended leave.

• A full-time trainer and analyst works on the team. "This is a significant advantage for teaching registration and verification in a consistent manner with accountability factors built in," says Murphy.

Retention is big challenge

At Mary Rutan Hospital in Bellefontaine, OH, inservices are held periodically for the patient access team. Recent topics covered have been cash up-front incentives, real-time eligibility patient dashboard, the staff member being "the first impression of our hospital," handing out charity/financial assistance information to patients, bad addresses, reviewing hospital corporate goals, and reviewing the compliance software.

"Staff have an opportunity to ask various questions on these topics or other issues they have encountered at their job," says **John Kivimaki**, director of patient accounts. Here are some actual questions staff have asked, with answers in italics:

• Can we collect on other accounts the patient has? *(Yes.)*

• What if the patient says his or her address is the address that is coming up "Mail Return?" *(If you cannot get an address, ask for a phone number*

where the patient can be reached or place of employment if not on the account.)

• What if the patient says he or she already has a charity application when you offer one? *(If we have one on file or pending, the system will show that in a pop-up-window. Please tell the patient to call the business office to make sure an application is on file.)*

To keep staff current on changes in insurance requirements, updates are e-mailed to all patient access staff immediately. "In addition, staff are encouraged to bring new insurance information presented at the time of registration to the supervisor's attention, so that this can be updated in the HIS system," Kivimaki adds.

Kivimaki says that he struggles with retention of quality staff members. "We lose a lot of staff to other areas in the hospital that do registration functions in a medical area, such as cardiology," he says.

Initially, patient access staff go through a well-developed training program. Through the initial training program for new employees, all patient access staff members are cross-trained in inpatient, outpatient, and ER registration procedures. "Since we are also responsible for the switchboard, training is also required in that area. When an opening comes up, a patient access employee trained in our program is of great value, with very little training needed," says Kivimaki. "These areas pay more because of their medical environment, and we end up losing some very good employees."

Patient access staff also receive hands-on training. The new person actually does the job duties while the experienced person observes and assists when needed.

"Any of our patient access team can fill in or replace staff when needed. We also have a number of part-time staff who are trained the same way as our full-time staff," says Kivimaki. "Many of these are always wanting more hours and fill in, especially during vacations. This is very cost-effective when covering an area 24/7."

[For more information, contact:

***John Kivimaki**, Director of Patient Accounts, Mary Rutan Hospital, 205 Palmer Ave., Bellefontaine, OH 43311. Phone: (937) 592-4015. E-mail: mrhbojek@maryrutan.org.*

***Jessica Murphy**, CPAM, Corporate Director for Patient Access Services, Methodist Le Bonheur Healthcare, Memphis, TN. Phone: (901) 516-8162. E-mail: MurphyJ@methodisthealth.org.]* ■

Do kiosks deliver what they promise?

Do they impact satisfaction, delay reduction?

If you want to know if computer kiosks deliver results when they are used to register patients, the answer depends on what results you're looking for. **John Woerly**, RHIA, CHAM, a senior manager at Accenture in Indianapolis, says that in some cases, patient access departments were disappointed with the results they saw after implementing registration kiosks. "This may be due to patients tending to still want face-to-face 'people' service," says Woerly.

According to **Beth Keith**, manager of ACS Healthcare Solutions, one of the biggest issues with implementation of kiosks has been that the cost savings in terms of staff have not been as significant as originally projected.

"The places that appear to be the most successful using the kiosks are those that see it strictly as a customer satisfaction feature. It allows people who are computer-savvy to register themselves rather than wait for someone," says Keith. "From my research, those facilities that have expected huge personnel savings have not been as happy, because the need for assistance has not gone away."

Typically, the patient has to be preregistered so that the appropriate insurance selections are made. "For a patient to move through the sophisticated registration systems to select the right choices for data that are needed for billing would not be a simple task," says Keith. "Some facilities use it to register that the patient has arrived." Patients select themselves from a list matching their name, sex, and birth date and then add some limited data, but are ultimately registered by a facility employee. "Those organizations have not reduced staff, but merely used the kiosk to enhance customer satisfaction," says Keith.

At Hackensack (NJ) University Medical Center, the decision to implement computerized kiosks was driven by the need to improve customer satisfaction, reduce delays associated with registration, and to improve the operational flow of arriving patients. The kiosks were implemented in two high-volume areas — physical medicine and rehabilitation and the Institute for Child Development. "Patients do like utilizing the kiosks," says **Alan N. Leipsner**, MPH, MBA, FACHE, the hospital's administrative director of

urology. "The development of proper interfaces is key to achieving optimum success with the kiosks."

One challenge in physical medicine is the use of kiosks by patients with injuries requiring braces and crutches. "This has been addressed through the utilization of staff to assist in the use of the kiosks," says Leipsner. "Additionally, we were faced with the issue of privacy, which has been addressed by side panels and putting one kiosk in a small office."

Fears were unfounded

Two big challenges patient access was facing in 2007 at the Medical College of Central Georgia in Macon were getting clean claims so they are paid as quickly as possible, and dealing with understaffing due to vacancies and people being out on leave. "We had lots of decentralized registration areas, and we were really, really struggling with how in the world to continue to staff these areas," says **Kim Whitley**, director, patient access and clinical intake management.

Kiosks were seen as a way to relieve these staffing issues. "As we look forward to the shrinking dollar of health care, we were looking to reduce overtime and FTE needs while maintaining a high level of customer services," says Whitley.

At that point, kiosks were being used in other markets but were not utilized in health care. "We had a really hard time finding a vendor, but we kept looking. It also took us a little bit longer than we hoped to get our project approved," says Whitley.

One reason for this was that higher-ups were worried that patients would not want to register themselves using kiosks. "There were some concerns that there would be issues with that. Once we convinced everyone that this would be fine, we were able to move forward," says Whitley. Two years ago, kiosks were implemented at the hospital's Georgia Heart Center, and patients began checking themselves in for medical appointments.

The fears about resistance from patients turned out to be unfounded, and the department boasts 96% to 98% satisfaction rates.

"The reason we know this is because at the end of every kiosk check-in, we have an automatic customer service survey," says Whitley. "We know in real time how our patients feel about the check-in process with the kiosk. We have a grid that we use to assess the area. This included the presence of preregistration, because obviously if you have a strong preregistration component then your patient will spend less time at the kiosk."

As for the rollout of the kiosks, Whitley says "we were looking at those areas we would get the best use out of it. We decided to roll this out in the procedural areas first. Once we got it under our belt and working, then we'd move on to other areas."

Although administrators were most concerned about the older patient population being dissatisfied with the kiosks, the elderly patients turned out to be more computer-savvy than expected. "And for those that may not be, they very rarely come by themselves," says Whitley. "So we really didn't have the obstacle that we had anticipated."

In addition, registration staff are always present to help patients, should they need assistance to get through the check-in process.

Kiosks were just implemented at a second registration site, and customer satisfaction is being measured using the same real-time survey. Patients are asked whether the registration process was easy, moderate, or difficult. Out of about 100 to 150 registrations, only about three patients check "difficult."

If patients answer "difficult," then they are asked a series of additional questions: Were you uncomfortable with self-service check-in? Did the screens move the way you wanted them to? Was your registration staff member courteous to you during the process? Would you like to be contacted?

"If we have any issues, we can address them right then and there. We don't have to wait until we get a survey back later on," says Whitley.

Delays dramatically reduced

Since patient satisfaction with registration was already measured before the kiosks were implemented, the department had a baseline to work with. "Most of our registration issues, when we didn't score well, were due to wait time," says Whitley. "It wasn't so much the actual registration process but how long it took to see a registration person and the time it took us to register them."

Previously, average wait times from the time patients walked in the door until they finished registration, including the time they waited for a registration person, were at around 32 minutes. "Now, in our heart services site, from the time the patient signs in until they finish checking in is six-and-a-half minutes," says Whitley. "So we are carving about 20 to 25 minutes off the registration time. It's been very successful for us."

For this reason, Whitley recommends working closely with clinical staff during the rollout of

kiosks. Kiosks were rolled out in the heart services area first, which had only two registration staff members. This meant that if 10 patients walked in at the same time, they could only be registered two at a time.

When the department went live with kiosk registration, suddenly all 10 patients could be registered at once. "This meant that patients were processed five times faster, so we had more patients going to the clinical area in a faster manner," says Whitley. "In order to be ready to accept them, the clinical areas had to adjust their scheduling."

Previously, the clinical areas had based their operations on a 30 to 45 minute wait time for registration. Since that wait time decreased significantly, more appointments could be booked, for example, in the imaging area. "They were able to go from 30-minute slots to 15-minute slots and increase the number of appointments, because people weren't being held in registration," says Whitley.

Staff are ambassadors

In the past year, kiosks were implemented in two of the hospital's freestanding imaging centers, a multiphysician clinic, and a family health center. "We have four registration areas in our main hospital that we have now consolidated to one area," says Whitley. Currently, the organization is in the process of rolling out kiosks in all of its surgical services and plans to add kiosks to its urgent care center, ED, and wound care and rehabilitation center.

Whitley says that "one of the most important aspects of success with kiosks is your staff. The kiosk technology works, but the *presentation* of the technology in a positive manner is what makes it successful. Your employees can definitely make or break the success of the project."

In other words, your staff have to act as "ambassadors," says Whitley. "Staff move from being the interrogators asking questions behind the desk, to moving next to the patient and assisting them with any of their needs. This changes the dynamics of the registration staff."

As a side benefit of kiosk registration, you can learn a great deal of information. "The computer tells you everything that's going on with your patient. It tells you who is scheduled, what time they are scheduled, who is checking in, who has completed the check-in, whether this is a Medicare patient, and many other aspects," says Whitley. "The person who monitors the activity of all of the kiosks has to be a highly functioning, multitasking employee."

[For more information, contact:

***Beth Keith**, Manager, ACS Healthcare Solutions. Phone: (985) 845-1559. E-mail: beth.keith@acs-hcs.com.*

***Alan N. Leipsner**, MPH, MBA, FACHE, Administrative Director of Urology, Hackensack University Medical Center. E-mail: ALeipsner@humed.com.*

***Kim Whitley**, Director, Patient Access and Clinical Intake Management, Medical Center of Central Georgia, Macon. E-mail: Whitley.Kim@mccg.org.*

***John Woerly**, RHIA, CHAM, Senior Manager, Accenture, Indianapolis. Phone: (317)590-3067. E-mail: john.woerly@accenture.com.]* ■

Get 'knock your socks off' participation with ladders

Many patient access departments have implemented career ladders, and many others are planning to do so, in the hopes of improving staff retention. However, participation is often disappointing.

One common pitfall is a lack of organizational planning. "The patient access management team should take the lead in establishing the foundation for the job ladder program," says **Ron Camejo**, director of revenue cycle practice at Chadds Ford, PA-based IMA Consulting. "A solid foundation must be established or the job ladder program will fail, either before or after implementation." He recommends doing the following:

• Take a close look at the organizational chart. Determine how to differentiate between an entry-level position and a more advanced position for each function in the department.

"Work with human resources to develop salary ranges and titles for each position, and to identify where current staff members fit into the new hierarchy," says Camejo. "Since there will be some budgetary considerations, the chief financial officer's blessing will be required for the job ladders to become reality."

• Make sure there are well-defined criteria for advancement.

Include the career ladder program in job descriptions and tie it to the employee evaluation process. Well-defined criteria should indicate details such as productivity and quality require-

ments, training prerequisites, necessary certifications, and the fact that managerial and supervisory promotions are contingent upon vacancies as well as qualifications.

"Staff members at all levels quickly grow disenchanted if they don't understand the criteria for growth within the organization," says Camejo.

• Communicate effectively with existing and prospective employees.

Introduce the job ladder program as part of the recruiting process, and review it in detail during the orientation process. It should also be a part of routine employee evaluations.

"You should be able to clearly articulate a strategy for advancement with employees," says Camejo. Advancement should be contingent upon meeting quality and productivity standards, cross-training in other areas of the department, certification by national organizations, and other organization and departmental requirements.

• Develop a comprehensive training program.

This is necessary to ensure that staff members are able to function optimally at the various positions, and are, therefore, able to advance within the organization. The training program should promote the department's goals for cross-functionality, and competency testing should be included to lend credibility.

"A comprehensive training program allows the organization to *develop* expertise, as opposed to always having to *hire* that expertise," says Camejo. "As a result, the pool of potential applicants can be expanded, with a focus on aptitude and attitude for entry-level positions."

Develop future PA leaders

At Carolinas Medical Center in Charlotte, NC, 12% of the corporate patient access staff participates in the department's career ladder program. The career ladder program is open to all registrars who have been employed for one full year and have a successful performance appraisal. Every new hire starts as a Registrar I and then has the opportunity to move up to a Level II and Level III. Each level comes with a change in the amount of incentive that the employee earns.

To sit for the Level II exam, staff cross-train to different areas and take continuing education classes. Passing the exam gives them a higher level of monthly incentive. To become a Level III, an employee cross-trains to different facilities and sits for the Certified Healthcare Access Associate (CHAA) exam. Again, passing the exam and becoming a Level III equates to a higher level of monthly incentive.

To participate in the department's leadership and development (LEAD) program, an employee must be a Level II registrar and be nominated by a manager. "Our LEAD program has given us a pool of internal candidates for management positions. We do two candidates in each class and do two classes per year. We have filled two supervisory positions from the LEAD graduates," reports **Katie M. Davis**, director of patient financial services.

Two pitfalls that can result in poor participation are rules that are too stringent, or mandating certification, such as CHAA, that the individual must pay for in advance, according to **Holly Hiryak**, RN, CHAM, director of hospital admissions and access services at University Hospital of Arkansas in Little Rock. "We typically pay for staff to certify at this time. But with these economic times, we are looking at requiring our access associates to pay for testing, then reimbursing them once they pass," she says.

Salary increases are always a motivator, says Hiryak, but recognition is important to staff as well. "Staff can have their designation added to their name badge as well as their signature on any correspondence," says Hiryak. "They also have the opportunity to take on more responsibility with the opportunity of moving into a supervisory or leadership role. If they choose not to participate, then they are left behind in terms of salary, responsibility, and opportunity."

[For more information, contact:
***Ron Camejo**, Director, Revenue Cycle Practice, IMA Consulting, 2 Christy Drive, Suite 219, Chadds Ford, PA 19317.*
***Katie M. Davis**, Director, Patient Financial Services, Carolinas Medical Center, Charlotte, NC. Phone: (704) 512-7181. E-mail: Katie.Davis@carolinashealthcare.org.]* ■

Are patients given financial counseling in your ED?

If not, you're losing money

Emergency department (ED) collections are notoriously difficult and often slip through the cracks, due to numerous challenges.

However, some patient access departments have found a way to overcome those difficulties and give patients financial counseling in the ED.

For years, Chicago-based Swedish Covenant Hospital's registration staff were proactive about notifying patients about their copays and deposits required for self-pay patients. "We would try to counsel patients about their payment responsibilities after they had been seen by the ED physician," says **Michael Vigan**, ED registration manager. "However, as the ED became busier and the importance of registration became emphasized, counseling patients about their copays and deposits became very difficult. And at times, it was non-existent."

With the support of the hospital's finance team and collaboration with ED physicians and nursing staff, a new process was implemented to capture the vast majority of patients with financial responsibilities in the ED.

When it has been determined that a patient has a copay/deposit, a note is placed in the patient's chart to notify the ED physician and nurse that the patient must be seen by registration before discharge. Upon discharge, patients are brought back to a "discharge area" staffed by an access services team member to discuss any issues regarding copays or deposits.

This process is very effective, but a portion of the population is still missed. For this reason, a 60-day ED financial counseling pilot program is underway. This pilot program involves providing financial counseling in the ED while the patient is waiting to be discharged.

"Since there are patients that bypass our discharge area, there is an opportunity to pursue other patient financial responsibilities, such as deductibles and previous balances," says Vigan.

An ED financial counselor investigates the patient's insurance to determine what financial responsibilities the patient has, as well as any previous balances, once he or she is ready for discharge. For patients with no insurance, the counselor can set up payment plans or help with finding financial assistance.

"There's so much we can do," says Vigan. "We have found that patients are more comfortable talking about financial issues immediately after their medical issues have been resolved."

The ED financial counselor works primarily during the evening shift and is the "go to" person for any registration issue that occurs. Since outpatient registration closes at 7:30 p.m. and admitting closes at 11 p.m., these duties are handled by ED registration staff.

One of the counselor's responsibilities is performing quality assurance on registrations done in the ED. "It is a collaboration between the lead and myself. She looks primarily at the new employees, and I do random checks with everyone else," says Vigan. "We register between 95 to 150 patients per day, so doing this between two people can be quite a task. But with the work we put in, we have seen a decrease in errors."

During the H1N1 outbreak, the ED saw a big surge in registrations. "Our challenge was to keep up with the registrations as they were coming in," says Vigan. The ED financial counselor arranged for extra staff during these busy times.

The ED financial counselor was promoted from the hospital's registration staff and has experience in almost all areas of access services, including admitting, outpatient registration, financial counseling, surgical scheduling/registration, and ED registration. "This makes her a great person to lead this pilot program. It's also easier to resolve issues when you have thorough knowledge of many areas," says Vigan.

[For more information, contact:
***Michael Vigan**, ED Registration Manager, Swedish Covenant Hospital, Chicago. Phone: (773) 878-8200 ext. 5457. E-mail: MVigan@schosp.org.]* ■

Revenue cycle gets make-over with technology

When Irving, TX-based Christus Health set out to improve its revenue cycle operations, it turned to technology and training in equal parts.

As a large health system with 40 acute care facilities, revenue cycle operations varied tremendously across regions. "As a result, our financial performance reflected the same degree of variation," says **Sandi Green**, CHAM, system director of patient access/revenue cycle services. "We needed to revisit the revenue cycle operations from a system-level approach."

Green says that in tackling this, "Our biggest challenge was resistance to change, and especially standardization. Every facility believes they are unique and has a need to be different. This was indeed our biggest task," says Green.

First, a corporate revenue cycle services (RCS)

department was created to provide leadership and oversight of revenue cycle operations across the system, and standardize communications and best practices.

The RCS department consists of director-level positions for revenue cycle areas of admitting, medical records, and patient financial services. Each of the system directors developed resource teams made up of the key leadership associates over these departments in all the facilities. The RCS directors offer onsite support for all revenue cycle functions in all facilities.

"This has tremendously changed our ability to make process changes and implement standard procedures in an organized and timely fashion," says Green. "We have created very positive working relationships with these leaders. We have come a long way in working together to find system-wide solutions to our issues and challenges."

Program improves staff skills

"One of our key focus areas was on patient access, the birth of the revenue cycle," says Green. A program was developed and implemented to promote and enhance the skill level and performance of front-end staff.

"This was a very comprehensive program that provided many hours of additional education to our staff," says Green.

The hospital contracted with an education vendor to obtain an extensive revenue cycle course curriculum. The "Excellence at the Front End" program was developed by the RCS department after a year of internal research on various issues affecting patient access areas across the system.

"The obvious issues that the industry suffers were no different to us — high turnover; changing demands and skill sets; lack of training and technology; and, more and more, responsibility of the outcomes," says Green. "Our program addressed all of these."

The team rewrote job descriptions to address outcomes and built a career ladder that promoted associates based on their demonstrated skill competency. Positions are no longer task-specific, such as insurance verifier or registrar. Instead, they're based on levels of skill competency.

Associates are also eligible to be promoted and compensated by obtaining Certified Healthcare Access Associate (CHAA) certification. "Although the certification is not mandated, it is required for promotion up the career ladder," says Green.

Multiple competency assessments are done for all new hire applicants to assess their basic skills in math, reading comprehension, and data entry. "We no longer consider registration an entry-level position and have modified our pay scale accordingly," says Green.

Green says that in her opinion, "this has by far been one of our most successful accomplishments in our organization. It has taken many years for folks to realize how the job has changed for patient access. It is very comprehensive and has so many opportunities for failed outcomes on the customer, financial, and regulatory side."

Although several hundred patient access associates have obtained CHAA certification, the process also has resulted in some turnover. "Not everyone is cut out to do this job," says Green. "It takes special people to do what they do accurately, be friendly, and of course, be fast."

Technology also key

Simultaneous with the educational program for staff, two new standardized technology solutions were implemented. First, an integrated application with the hospital's registration system allows for eligibility verification and data validation during the registration screen flow. "This eliminated the multiple web sites that were being used to obtain and verify payer data," says Green. Another application performs charity qualifying screenings.

In addition, an automated system was implemented to provide registration data element audits *prior* to bill drop. "This has moved the edits for successful billing to occur promptly after the registration so corrections can be made and our bills are clean when they drop," says Green.

In less than one year of implementation, some facilities reached the standard of 94% accuracy,

and other facilities are very close to achieving this standard as well.

"The improvements in the patient access department are clearly reflected in improved patient financial services performance metrics related to A/R," says Green.

Previously, staff contended with long lists of telephone numbers, web sites, and faxed forms to obtain benefits. "We literally had many process maps, depending on the payer," says Green. "Some staff used these resources well, and others did not use them at all. Therefore, there was no consistency in the verification process." Since obtaining eligibility was such a time-consuming task, it often was never done on many accounts.

With automated eligibility verification, staff are alerted when there is a discrepancy between the information on the account and the payer database, which allows the account to be updated.

"It also validates that we have selected the correct insurance assignment based on the plan information," says Green. "This was especially good for the managed Medicare and Medicaid plans."

It also helped ensure that in patient financial services, the proper contractuals are posted to the revenue. "This has saved us tremendous rework on the back end to correct and recalculate the adjustments," says Green. "In addition, we can validate the guarantor address with the USPS, which helps reduce return mail form simple data entry mistakes."

The system confirms that all the necessary steps are taken, and if they are not, this is reported with a daily list of every account by associate. "This level of performance detail has produced the consistency we were looking for," says Green.

[For more information, contact:
***Sandi Green**, CHAM, System Director, Patient Access/Revenue Cycle Services, Christus Health, Irving, TX. Phone: (713) 277-2254. E-mail: sandy.green@christushealth.org.]* ■