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IN THIS ISSUE

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Toot your own horn to command long-overdue respect for access

Department is 'underestimated and unrecognized'

Patient access often is the recipient of all kinds of negative feedback — from patients, other departments, and even senior leaders. It's up to you to get the word out about your department's successes.

"Patient access is one of the most underestimated and unrecognized departments in the health care setting," says **Connie Campbell**, director of patient access at Mercy Medical Center in Oshkosh, WI. "It is often entry-level pay for the critical things they need to do. In light of that, you do need to toot your own horn. But none of us are very good at that."

For a very long time, patient access has been thought of as people who "only know how to type," says **Suzan Lennen**, CHAM, manager of patient access at Saint John's Health System in Anderson, IN. "After 35 years of experience in patient access, I can very firmly say that we have to know far more than typing skills."

Today's patient access representative must have knowledge of insurance eligibilities, payer requirements, Medicare and Medicaid rules, and systems for ordering tests in clinical systems by non-clinical personnel, "not to mention the vast customer service skills each person must keep as a top priority with our patients," says Lennen.

Unlike other areas of the hospital, however, patient access is not accustomed to calling attention to its successes. "We are busy taking care of the patients' needs as quickly and as efficiently as we can," says Lennen. "There is not much time to sit back and reflect on our achievements."

There is no question that what patient access does affects *all* parts of the organization — ancillary departments, nursing, food services, pharmacy, health information management, and patient billing. "But if we don't make known what we are doing, it is usually left unnoticed. Many times, the only 'notice' patient access will receive is when things are *not* right," says Lennen.

Patient access staff are unfairly depicted, for instance, as being

incapable of getting the right registration information. "What is *not* known by other departments is the amount of time that a representative will take to track down the right information," says Lennen.

If the registration representative is not able to talk directly with the patient, he or she must rely on historical information, or that of family and friends. "There are also times when patients decide not to give us accurate information, making our efforts even more difficult," says Lennen. "Sometimes the inaccurate information is not caught until after the fact. The 'clean up' of wrong or false information then has to be corrected at nearly every point the patient 'touched' while in our facility."

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Show bottom line proof

Campbell says that "'out of the ordinary' patient encounters do need to be highlighted. Always telling your department's story or highlighting one of its recent efforts is essential at any meetings the patient access manager attends."

Recently, a customer at Mercy Medical Center got separated from his wife on their anniversary. As they waited for each other at opposite doors of the hospital, access staff helped them find one another, and then gave them a bottle of "bubbly" — apple juice. "We keep four bottles on hand at all times for special occasions that staff can use for patients," says Campbell.

This is an example of an "out of the ordinary" effort by access staff, which Campbell goes out of her way to call attention to. Another involves a tradition started by access staff during the holiday season. Black-and-white photos are taken of children, with parental permission, and these are hung on the department's 16-foot Christmas tree. Each family is then sent a holiday card with the child's photo.

According to **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital, "the proof is in results. We report through finance, and finance is a bottom-line world. In turn, my department speaks in bottom line success stories."

Goals and objectives are created each year for the department. "I report quarterly progress to my boss and this is provided to my senior executive," says Pallozzi. "I pride myself on the department's ability to achieve its goals. The only way to make it happen is with a strong leadership team that embraces the goals and objectives of the department as their own, and holding their staff as accountable to our success as I hold the leadership team."

A monthly newsletter is sent to Pallozzi's boss and senior director, with key performance indicators listed. "All literature points to recognition as a key to retention. Recognize and celebrate the smallest and greatest of successes," says Pallozzi. "You cannot wait for someone else to do it for you."

Pallozzi says to call attention to your copayment collections, both as a department and for individual achievements, registration accuracy, Medicare as a Second Payer accuracy, turnaround

times, patient throughput times, and collection of high-dollar accounts.

Pallozzi sits on the hospital operations group, and is required to report key performance indicators twice annually. "I take full advantage of apprising executive leadership on copayment collection year to date, improvement from the previous year, as well as any significant strides made in the improvement of accuracy rates," she says.

Individual accomplishments regarding accuracy are noted in the department's monthly newsletter. "We have a Medicaid application unit, and we know how difficult that process can be," she says. "I have had staff work doggedly to get the needed documentation on six-figure accounts. Imagine how good they feel when they have secured the Medicaid funding."

As for the reputation and image patient access has at your hospital, "how you and your staff conduct yourselves, during all your interactions with physicians, patients, co-workers, and colleagues, can be a very significant gauge of that," says Pallozzi. These customer service interactions, whether done by phone or face to face, answer the question: "Are you providing the department what they are expecting and delivering each time?"

Go above and beyond

"The patient access staff must be able to multitask on many levels," says Lennen. "There are times when a registration representative will see a need from a patient, and go above and beyond to see that need is met."

This might entail something as simple as pointing out the location of a hospital department where a patient is to receive a diagnostic test, or as complex as finding out if Medicare will pay for it. Or, a physician office may call to give information on a direct admission to the hospital, while the registrar who answered the phone is in the middle of registering a patient who is very ill and needs to get on to their testing site in an optimal time frame.

"When we do receive a compliment from a patient, we make sure the people involved in that person's care while at our facility know that they were appreciated," says Lennen.

Such compliments are sent on to senior leadership, including the hospital's director, vice president, and president. Occasionally, the president will send a thank-you letter, along with a small gift. "Something as simple as a thank you can be so important," says Lennen. "Sometimes the 'above and beyond' things that take place are common-sense types of issues. But these are still are important to the patients."

Recently, an access staff member loaned a family her child's car seat after they had been in an accident and were being transported by friends to another location after their emergency department visit. "The registrar didn't have to do this, but it was what was needed at the time," says Lennen. "Many other things that are in our scope of care as patient access occur every day."

Staff routinely help patients figure out which of their many insurance cards are the current ones, explain patient privacy rights, and obtain the proper consent for each patient that enters for care. Each staff member must know the hospital's policies, as well as state laws, for what is considered a legal consent.

"We are in an economy that is struggling, especially with the issues of health care costs," says Lennen. "It is vital that those of us that are working to ensure the right information is obtained the first time, are recognized for the efforts made, every day, every hour, for every patient."

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Hiring new staff? Think carefully, then think again

Customer service is a must

With most hospitals looking more closely than ever at their bottom lines, the last thing that patient access needs is high turnover. Not everyone is cut out for the access department, however. It's a lot easier to hire correctly

than to try to work with — or in extreme cases, fire — a person who's not right for the job.

"People skills are a must, but nowadays staff also need skills in critical thinking, insurance, and financial counseling," says **Connie Campbell**, director of patient access at Mercy Medical Center in Oshkosh, WI. "The person must thrive on change and be able to adapt daily to new scenarios. He or she must be able to calm customers, and get to the bottom of why they are here right away."

In addition to covering the routine matters of education and work-related experience, Campbell says that she always asks potential hires these interview questions:

• What was your favorite board game to play as a kid?" "Registration really needs someone who likes to pay attention to detail. Thus, you think differently when someone chooses Candy Land vs. Monopoly," says Campbell.

• What kind of student were you in high school and what was your favorite subject? "Someone who loved science will love the ER setting," notes Campbell.

• If you had a patient sitting in front of you, an overflowing sink behind you, and a fire in the wastebasket to the left, what would you do first? "This one tells me if they can think on their feet. It is important they know what to do first," says Campbell. "Patient safety is *always* first. That is something that can't be taught. It needs to be known. Some of the answers you get are amazing."

• If you had a patient state their chest feels tight while you are asking them their home address, what would you do? Or, if a mother less than 18 years old with a newborn comes in with new insurance, what are some options she might have? "These answers can be taught, but the question gives me a sense of what they do know already," says Campbell.

• Where do you see yourself in five years? Two years? Next year? "This really helps you to know how long they will stay. It also lets me know if this is a career for them," says Campbell.

Ask for examples

Katie M. Davis, director of patient financial services/patient access/pre-service at Carolinas Health Care in Charlotte, NC, says that she uses "behavioral interview questions" so candidates will give examples of how they have handled issues in the past. Candidates are asked to "tell me about a time you were working under pressure and how you handled that."

"This is one good indicator of how they would react if a similar situation occurred at your facility," says Davis. The hospital's corporate patient access department uses testing as a way to verify skills of candidates. In addition to showing proficiency with Windows, Word, and Excel, an individual also demonstrates customer service skills. As part of this assessment, the candidate responds to a recorded call. "These skills tests give us perspective as to the candidate's critical thinking skills, listening skills, and their ability to understand the customer's needs," says Davis.

A common pitfall is to be misled by a candidate's "hype." "To keep that from happening, we do panel interviews that include a cross-section of different staff," says Davis. During the interview, each participant scores the candidate on a scale of one to five. At the end of all the interviews, the scores are tallied and the two or three highest-scoring candidates come back for a second interview with a different panel.

"Interviewers who make up their minds based on feelings, instead of utilizing the test scores and interview questions to determine who is hired, will often make a hiring mistake," says Davis.

Carole Helmandollar, executive director of ambulatory services at Children's National Medical Center in Washington, DC, says that she looks for people who show initiative.

One way she does this is to ask a question such as, "What is the worst thing that has ever happened to you?" "I then ask questions to get at how they handled it and what role they played in the events leading up to it," Helmandollar says. "I got this idea from a seminar I went to a few years ago and shared it with some of my peers who also use it as a screening tool. We want to hire people with positive attitudes for the front line."

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Take these steps if a staff person isn't measuring up

Documentation is key

With all the data typically collected by access departments on individual staff members these days, it's easy enough to tell if an employee isn't up to par. But what action should you take, if you see that an individual's accuracy, collections, or patient satisfaction data are poor?

"Of course, selecting the right candidate for this type of position is key," says **Tina Williams,** director of access services at Monroe Carell Jr. Children's Hospital at Vanderbilt University Medical Center. "Patient access is no longer a clerical position."

"Regulations and technical challenges for patient access are massive and ever-changing," says Williams. "They must have strong communication skills, as they are dealing with people in crisis and asking questions many are reluctant to provide. They must also have compassion, as the situations these patients or their family members are facing may be overwhelming."

Once you are convinced you are hiring the right person, "it is important to provide clear documentation and training, from the moment the employee begins work," says Williams.

Turnover reduced 51%

Monroe Carell Jr. Children's Hospital's admitting department created an electronic way to track new hires and tenured employees learning a new job function. A training questionnaire is used, with a specific group of questions set up by the employee's manager.

"We require staff who are training a new member of the team to complete the questionnaire at the end of each shift," says Williams. "This can be done with very little upfront money or skill."

The information is automatically sent to the director and the manager of that employee. "This allows us to get up-to-date information on the progress of the employee. We can address issues during the orientation period and allow the employee to self-correct," says Williams.

A typical new employee training evaluation form might contain these questions:

Under the "conduct" heading:

- Was the trainee attentive?
- Did the trainee appear interested and eager to learn?
- Did the trainee take instruction and constructive criticism well?
- Did the trainee provide excellent customer service?
- Did the trainee display good teamwork skills and seem eager to help peers when able or needed?

Under the "principles" heading:

- Was the trainee at their assigned work station on time?
- Did the trainee take an excessive amount of breaks or abuse time limits?
- Did the trainee violate company or department policies (for example, were there excessive personal calls, cell phone or Internet use)?
- Did the trainee wipe down his or her station and keep it well organized, stocked, and presentable?

Under the "progress" heading:

- Was the trainee's speed adequate for the amount of training he or she has received?
- Did the trainee show an ability to multi-task and do so without difficulty?
- Did the trainee comprehend the information without being told repeatedly?
- Did the trainee appear comfortable enough to run the station without instruction from the trainer?

The trainer is free to provide additional information he or she feels is relevant in a comment section. This may include positive comments, additional training the employee needs, or examples of skills mastered.

The training tool is located on the department's web site, so that every employee can complete his or her evaluation easily. These are collected by management electronically and placed in the employee's file, to be referred to during the 30, 60, and 90 day time frames of the evaluation process.

"For the most part, the evaluations are on the mark. The staff know faster than the managers if they are meeting expected progress. It also allows us to remind others that people learn at different speeds and by different methods," says Williams. "We have reduced our turnover rate by 51% in the past two years since we implemented this process." The tool also allows staff to re-evaluate the type of trainer the employee is best suited to.

Williams currently manages staff in

admitting, operating room registration, front-end radiology, the transfer center, bed management, environmental services dispatch, and telephone triage. Since each of these jobs is different, some of the questions are customized to the specific role that is being performed. Once the questionnaire is set up, though, there is no real maintenance other than to add the employees' names, as these are removed when the training is completed.

"This is not a quiz, so there is no right or wrong answers," says Williams. "It is an assessment tool that the trainer completes on how they think the employee did for the day. We also ask the trainer to tell us how many times the employee has been trained on the specific task." In addition, the trainer reports whether the employee was dressed appropriately, whether notes were taken, and whether the employee's performance reflected the amount of training he or she has received thus far.

"The beauty of the system is that it sends me, and the manager for that specific area, an e-mail. I can read and intervene based on the comments and scores, even though I do not get involved with the day-to-day operations of each area," says Williams. "It helps me mentor my managers in the growth of their management styles."

In one case, the trainer gave a trainee low marks in attentiveness. In the comment section, she added notes explaining that the employee was very nice but didn't seem interested and did not take notes. "We called the employee in immediately to ask them how they thought training was going. We relayed the observations that the trainers felt about taking notes and paying attention," says Williams.

It turned out that the employee was unaware that the trainer had gotten a negative impression. "We provided pointers on how to avoid things that could be mistaken for being disinterested," says Williams. "Even if you don't learn by taking notes, it is often perceived as a sign that you are interested when notes are taken. It is also required that each employee take notes during training, so they can refer back to them throughout their orientation period."

What you must document

Once it becomes apparent that an employee is *not* meeting expectations, Williams' advice is to "document, document, document."

Providing performance plans to assist the employee with self-correction is the first step. "If the employee does not stick with the plan, then the manager must hold the employee accountable," says Williams. "Documenting meetings, missed deadlines, and errors can make the difference in the manager, and sometimes the employee, feeling like they were given every opportunity to make it work. There are times when it is just not a good fit."

Here is an outline of what is covered in performance plans used by Williams:

List of concerns

- Job performance.
- Communication performance.

Job expectations

- Deadlines and re-occurring assignment dates.

Performance Plan

- Progress information, such as checkoff lists and organized notes, are reviewed.
- Training questionnaires are reviewed.
- The employee is required to communicate any information or tools they feel would assist them in their success. "Some employees request additional training with the departmental trainer, some ask for a different trainer than the one they have been assigned, and some ask for printed materials," says Williams.
- Weekly meetings are required. "The responsibility of scheduling and keeping the meeting is on the employee," says Williams. "These meetings continue until management feels the employee is meeting expectations."

Carole Helmandollar, executive director of ambulatory services at Children's National Medical Center in Washington, DC says, "We have union-represented staff in our patient access department so we start out with verbal counseling to review where they are not measuring up," she says. "We re-train them on that area of weakness, give them a grace period, and then re-measure them."

If there is no improvement, then the disciplinary process is started. "It is much easier to get the staff person to turn around when the problem is based on a quantifiable area like registration errors or denials. When it is a customer service problem, it becomes much more difficult," says Helmandollar.

The department is about to launch a customer service training program that will define the behaviors the employees are expected to demonstrate consistently. "We hope that will

help us hold the staff accountable in a way that is perceived as fair and objective," says Helmandollar.

The customer service training is still in development, but the goal is to tie specific behaviors with the department's standards for service. Staff are required to make eye contact, greet patients checking in for appointments, make sure that all concerns are addressed before ending a phone call, and never say "I don't know" or "That isn't my job."

"We do patient satisfaction surveys that ask questions specific to these behaviors," says Helmandollar. "We track these responses in an access database, and then identify training needs by area. While this tool doesn't identify the individual employee who isn't adhering to the standards, it gives us a sense of where the problem, even if we can't narrow the negative feedback down to a specific person."

A good quality monitoring program allows you to identify performance issues early on. "*Early on* is the key," says **Catherine M. Pallozzi,** CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital. Your program should track registration accuracy, Medicare as a Secondary Payer accuracy, copayment collections, and include a feedback tool to keep employees apprised of trends, she says. A quarterly dashboard can be used to track unscheduled absences and tardiness.

"Providing the data to the employee, and identifying trends, can assist the staff member to focus on areas of opportunity," says Pallozzi. "We have developed a legend for all registration and Medicare as a Secondary Payer errors. Staff members can easily identify the trends."

Armed with all of this data, you just may be able to turn a bad situation around. "The more specific the information you can provide to your staff member, the better the result," says Pallozzi. If coordination of benefits and insurance assignment needs work, a remediation plan can be developed specifically targeting that area.

On one occasion, a tenured staff member had inconsistency in her registration accuracy rate, which was in the 60th percentile. A training specialist trended her errors and spent focused time with the staff member away from the work area. "Her accuracy rate hit 89% within 45 days of the one-on-one remediation," says Pallozzi. "It was an extraordinary effort by the staff member and the training team, but a success!"

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Electronic systems verify coverage on the spot

Denied claims, days in AR reduced

A patient hands you an insurance card with multiple numbers, numbers that are next to impossible to locate, or no numbers at all. Another patient neglects to mention that his or her insurance status has changed due to a job loss. Either way, insurance verification in real time could prevent a denied claim for the patient standing in front of you.

"With the current economy, we see a larger number of patients with no insurance or patients who have gone under an assistance program," says **Kerri Sternhagen**, patient business services trainer at Affinity Health System in Appleton, WI.

"All hospitals are seeing a substantial increase in patients whose insurance has changed since the last time patients were seen," says **Cheri S. Kane**, MSA, FHFMA, CHFP, FACMPE, division president of The Outsource Group in St. Louis and former vice president of revenue cycle at Grady Memorial Hospital in Atlanta. "In one Georgia hospital, self-pay patients recently increased from 5% to 18% due to employer layoffs in the local area."

For inpatients and high-dollar claims, Kane says that you might want to ask patients the questions: Have you recently been employed?" "Do you have access to COBRA?"

"If so, hospitals today are evaluating if it is cost effective to pay the patient's backdated payments so they can receive COBRA and subsequently file insurance," says Kane.

John E. Kivimaki, director of patient accounts at Mary Rutan Hospital in Bellefontaine, OH, says that his department has seen a large increase in the number of patients whose insurance status has changed over the past couple of years.

"The condition of the nation's economy, where jobs have been drastically cut and health care benefits slashed, has generated this change," says Kivimaki. "We have clear

evidence of this large increase here in our area. The accounts we have written off to our charity and financial assistance programs have increased approximately 70% from October 2008 to October of this year."

Many of these patients are qualifying for assistance programs either because they no longer have jobs or because they have seen their health insurance coverage reduced tremendously. "This creates increased patient liabilities they cannot pay," says Kivimaki.

This scenario is uncomfortable for both the patient and yourself. "It is sometimes awkward when a patient comes in and their eligibility shows inactive," says Sternhagen. "If this occurs, the patient access staff will verify the policy and group number from the insurance card and try running the transaction again."

If the insurance eligibility still comes back as inactive, the patient is informed of this, and asked whether he or she has recently changed insurance or employment status. "If the patient says nothing has changed and they are still employed, we will keep the insurance listed as we don't want to alarm the patient. Sometimes slight changes in a patient's plan can appear to be inactive temporarily. We will ask the patient to contact their insurance company to check eligibility," says Sternhagen.

Sometimes, though, the patient just hasn't told access staff the truth — that they no longer have any coverage. "There will be times when the patient does not tell us their insurance plan is inactive. After verifying the information and it is determined the patient has no coverage, we will list them as private pay," says Sternhagen. The patient is given contact information for the hospital's business office, in order to get assistance with his or her financial situation.

To avoid a situation like this, though, private-pay patients are typically contacted before their appointment and assisted with any programs they may qualify for.

At Mary Rutan, all self-pay patients are given information on how to apply for assistance. "We also have charity/financial assistance in our statements. Our 'early out' vendors also are letting patients know of the assistance available to them," says Kivimaki.

"Many patients are failing to inform hospitals that they are self-pay," says Kane. "Patients are fearful that they will not be treated, or that they will be pressured to pay amounts that they don't have the funds to pay."

Recently, Affinity Health System implemented an online eligibility tool. This simplifies registration by obtaining patient information in real time from participating payers.

"Insurance eligibility, policy and group numbers are returned back from contracted payers, showing any discrepancies we may have from what the payer has on file," says Sternhagen. "A higher volume of claims are sent to the insurance company 'right the first time.'"

At the time of registration, staff already know if the patient is active or inactive. "This gives us an opportunity to ask more questions from our patients, to ensure they are giving us the most accurate insurance information," says Sternhagen. "Our days in accounts receivable for September 2008 were 40.18. In September 2009, they were at 35.25. We're excited to see the decline in the outstanding days in A/R."

The patient access department at Mary Rutan Hospital has seen similar success since it implemented electronic eligibility in 2004 to verify insurance information. Initially, a batch process was utilized, where files of daily registrations were accessed by the vendor and then sent to payers for eligibility verification.

For the last year, however, the department has used a patient dashboard to do a real-time verification of eligibility at the time the patient is being registered. "We still have the batch process running to give us valuable information on copays and deductibles that is sometimes unavailable from the dashboard," says Kivimaki.

This eligibility process gives up-to-date insurance information on policy numbers, policy holders, copays, and deductibles, depending on the payer. "Any information that the patient gives us at the time of registration or pre-registration is verified with the payer immediately," says Kivimaki. "We receive the payer's response in less than 30 seconds."

If the payer response comes back ineligible, staff can then tell the patient that he or she has no coverage with that plan. "A lot of times, the employer has changed their insurance and has not distributed the insurance cards to their employees," says Kivimaki.

The same eligibility process is used to verify insurance coverage if patients have called in to report a change in coverage. The patient may not know his or her specific payer information or policy number, so this is obtained by staff directly from the payer's response. "We then have all the necessary information to bill the account

correctly," says Kivimaki. "This has prevented a number of claim denials in this area."

$1.2 million is uncovered

Mary Rutan uses the same eligibility process to identify Medicaid managed care plans of Medicaid patients and Medicare Advantage patients and their specific plans and co-pays.

Registered self-pay accounts are run against the state's Medicaid eligibility files to determine if the patient has Medicaid coverage at the time of registration. As a result of this practice, $1.2 million in Medicaid billable accounts was uncovered in 2008. "We have uncovered many accounts where Medicaid applications were pending or just recently approved," says Kivimaki. "We also created two other files that are run against payer eligibility files. These have brought a substantial amount of money to our hospital."

First, a pending bad debt file is run once a week, which consists of accounts ready to be charged off as a final check before they go to bad debt. "The other file we have created is a bad debt file. This consists of all bad debt accounts with dates of service within one year of the date the report is run," says Kivimaki. "This is done since our state has a one-year billing time limit for Medicaid-eligible accounts."

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Are physician offices saying great things about access?

Patient access managers worry a lot about how satisfied patients are with their services, but physician offices are another type of "customer" that requires attention. **Cheri S. Kane**, MSA, FHFMA, CHFP, FACMPE, division president of The Outsource Group in St. Louis and former vice president of revenue cycle at Grady Memorial Hospital in Atlanta, says that "communication, communication, communication" is the key.

"A hospital's physicians are key to assuring the hospital's success. Failed communication will create dissatisfaction between the patients and the physician's office team," says Kane.

This can cause problems with everything from the patient's admission status to loss of funds due to lack of pre-authorizations. "It is important to ask physicians and their staff what the issues are, and work to address the issues by developing new processes," says Kane. "If the physician's staff are pleased with the communication from the hospital, the physician will be also."

Give a single point of contact

Dee Sutton, manager of central scheduling and concierge services at Bon Secours Hampton Roads Health System in Portsmouth, VA, says that her department now gives physician practices the option of being assigned a concierge. That individual is responsible for scheduling, registration, insurance verification, and obtaining authorization if needed.

Previously, the doctor's office had to contact scheduling, then a registrar would contact the patient, and ultimately, the doctor's office was responsible for tying up any loose ends. "It's definitely been a successful program. The physicians love it because they have one contact person," says Sutton. "This provides a 'one and done' opportunity to our physician practices."

The concierge also follows up to make sure that the physician got the report, and makes sure that the physician's office sends over any clinical records that are necessary.

Sutton says that while most practices can benefit from this service, "there are still some practices out there which like to have their hands in the scheduling and authorization process. Concierge is not ideal for those practices."

Those practices still call in their own scheduling and hand off the process to registration, which contacts the patient. "From there, it goes to the insurance verification teams, who verify the benefits and that the authorization is per-

formed. And sometimes it's still up to the physician practice to do that," says Sutton. "We still follow up to make sure that the patients came in, and if a patient didn't show, we do follow-up on those. We still provide that authorization service the standard way if it is requested by the practice."

A committee process is used to determine whether a given practice would benefit from the concierge program. "If a practice reaches out to us and says they are interested, then we pull up information on that practice," says Sutton. "A committee then decides whether or not it's a good practice for this, considering many factors."

Once practices *are* using the concierge system, however, Sutton says "they are very happy. Once they are on it, they don't back away from it. Most practices out there would be happy if you just provided the insurance authorization service for them. But when they have one person handling everything from A to Z, and they are taking care of all of your referrals, that increases customer satisfaction tremendously."

The concierge system has given patient access staff an opportunity to work more closely with practices. "We are able to make them aware of procedures that require authorization," says Sutton. "Before, there was no ownership. They were calling into a central scheduling department. Even though the scheduler would tell the physician practice that they needed a medically justified code, there were so many calls coming in that sometimes the follow up was done and sometimes it wasn't done. Now, it's not going to get swept under the rug."

High frustration levels

Patients may have misdirected anger at patient access due to issues that actually have more to do with the provider's office. For instance, patients may become frustrated due to being put on hold when calling for an appointment, or not being able to get an appointment as quickly as they would like. Guess who they convey their displeasure to?

"Patients used to have a different perspective of physicians," says **Patti Johnson**, patient access clinic director at Affinity Health System in Menasha, WI. "Nowadays, patients feel their time is just as valuable as the physician's. And oftentimes, the patient takes their frustration out on the patient access staff."

Patients are annoyed when asked to repeat the same information each time they come for an appointment. "They think we should just know it already," says Johnson. "In most cases, we do have the correct information. But since it can change at any time, we need to make sure so we can file the claim correctly. We streamlined our registration process about 18 months ago by asking *only* the required questions to get a claim filed correctly."

Patients don't realize, however, that staff are required by the government to ask some of the information, such as Medicare Secondary Payer questions. "Some of our sites are doing pre-registration, calling the patient a day or two prior to the appointment to get the information," reports Johnson. "We are also in the process of implementing a patient portal. I think that will help with this issue. Patients will be able to update the information in the comfort of their home or office, at a time that is convenient to them."

For their part, patient access staff are challenged to identify and enter the correct insurance information in the practice management system. "Each provider has their own rules, dos, and don'ts. It is impossible to remember everything," says Johnson.

To shorten hold times during large call volumes, Affinity's access department has introduced phone menus, such as asking patients to "Press one to schedule an appointment."

"It's not ideal, and actually is probably more displeasing to some patients. However, it gets the call to the right departments and does save the patient time being put on hold," says Johnson. "Some departments have also added an informational message to play while the patients are in queue."

As for the problem of providers running late, about 15 minutes in the morning and afternoon is reserved to allow for some catch-up time. "This is a rough one to manage," says Johnson. "For patients that have a reputation for taking extra time, we attach a patient alert to the patient's account that instructs the scheduler, 'When scheduling this patient with Dr. So-and-So, always allow 30 minutes.' This has been very helpful."

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Quell worries about H1N1, other contagious illnesses

When you think of hospital staff on the "front lines" during a flu epidemic, emergency department and other clinical staff probably come to mind. Don't forget that patient access staff also are in close contact with patients, many of whom have contagious illnesses including H1N1.

"We have already had three people who have contracted it by admitting patients for swine flu," says **Kevin McAndrews**, system vice president of patient financial services for PeaceHealth in Bellevue, WA. "We have gone through all the hand-washing protocols, but there is no question that staff are worried about it. We need to have a greater emphasis on not having to sit down with the patient face to face, and using technology instead."

The department is trying to increase the use of bedside registration in order to limit contact with access staff, and is currently considering implementation of kiosks for registration. "We stopped short of having all the registrars wear masks. This is going to be a challenge for us," says McAndrews.

Connie Campbell, director of patient access at Mercy Medical Center in Oshkosh, WI, suggests inviting your infection control department to come down and talk to your staff about the precautions they can take. "Have them actively assist with making sure there are masks and gel at the main entrance desks," she says.

Also, review various scenarios during unit meetings, based on current guidelines from the Centers for Disease Control and Prevention. "Answer questions such as, 'If a patient has a mask on, can I still get sick? 'If I do get sick, how long do I stay home for?'" says Campbell. "For those interested, give them actual web sites so they can read the information for themselves."

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Collect stories from staff, show what they *really* do

When she stepped into a new role as a patient access manager at Menasha, WI-based Affinity Health System, **Jackie Mitchler** says she was amazed at the amount of skills and information that all of her staff had to know and learn. "Then I went to management staff meetings and heard about all the clinical kudos and news, and nothing about registration," she says. "I had heard time and time again that registration was a kind of dumping ground. I could see morale was low."

One day, Mitchler came into work after a sleepless night, worrying about how she could turn the situation around. She began thinking about a presentation she had given recently at a local high school, to explain what the position of patient registrar entailed. While speaking to the students, Mitchler had shared a few anecdotal stories from her staff. Possibly, she thought, the same method could be used to garner much-needed respect for her department.

"Patient access, outpatient testing, and scheduling are the face of a health care organization. It is all about the people, isn't it? That's what makes patient access — the staff and the patients we take care of," says Mitchler, currently the organization's patient business service revenue cycle analyst.

Mitchler began by asking staff at a department meeting if they would mind giving her a per-

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sonal story about doing their job. Most of the staff thought the idea was a great one, and noted that nobody had ever asked them to do this before. One staff person said she was "not too good at putting her feelings down on paper" but wound up contributing a compelling story.

"When I explained to them that I wanted upper management and the entire organization to know all about them and what they do, they were willing to offer their stories," says Mitchler, who e-mailed the compiled stories, titled "Behind the 'Eyes' of the Patient Access, Outpatient Testing and Communitywide Scheduling Departments," to upper management.

"When I shared the book with one of our lean facilitators who works with this department, he looked at me and said, 'I am speechless. I have never seen this done before and it's excellent,'" recalls Mitchler.

Mitchler says that her major goal, to achieve recognition, respect, and admiration for her staff, was clearly achieved. "It is not possible to not gain all of those things for those folks and this department after reading our book," she says. "Every patient access department should have a book just like this. It helps you to really know about the staff, and it does help build morale. It's also nice to have and reflect on for years to come."

Mitchler says she is looking forward to additional input from senior leaders. "I have found that when something like this is created and sent out, oftentimes the change is not so much in an e-mail, but rather their reactions show it. I think of the old saying 'actions speak louder than words.' So, we shall see."

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