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Are you sure—really sure—that access staff aren't being rude?

Find out for yourself

Customer service is more important than ever for access departments. So managers can't afford to let "closet rudeness" go undetected. "Customer service is one area that patient access has no choice but to be on top of their game," says **Suzan Lennen**, CHAM, manager of patient access at Saint John's Health System in Anderson, IN. "We are the first contact for most patients. What we say and do sets the tone for the rest of the patient's visit to our facilities."

Patients want to be treated as though no one else matters, and "this is something that our associates just cannot get too much education on," says Lennen. "Treating people with respect and kindness is always the right thing."

If poor customer service is not dealt with immediately, poor habits will be repeated by the employee and perpetuated throughout your department. "The ultimate result is a negative reputation with our patients," says **Susan M. Milheim,** senior director of patient financial services at the Cleveland Clinic in Independence, OH.

Yet, frustrations are growing in access, partly due to patients experiencing more anxiety over their finances. "I think the patient population as a whole is struggling with the downturn of the economy. That means loss of jobs, increased patient financial obligations, and uncertainty about out-of-pocket costs," says Milheim.

At the same time, access staff are being challenged to do more with less. "As the economic hard times have hit the health care industry, open positions are not being filled as quickly. Overtime is being limited, and as a result, employees are being asked to work harder," says Milheim. "Delays may occur, creating frustrations for the patient. Patience lowers and tempers rise."

Can you be sure your staff are gracious under these considerable pressures? Here are some approaches to know for sure:

- **Audit telephone calls.**

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Milheim says that she randomly audits calls made by patient access staff, as part of the department's quality assurance initiative. She makes a point of listening to any calls involving a patient alleging that an employee was rude or mean. After she's heard the call, the employee is brought in to listen to it.

"The employee can hear how they talked to the patient. Sometimes we say things and we don't realize how we're saying it," says Milheim. "That typically is a great coaching tool."

One employee was asked to listen to her own responses to a caller, which were short and sharply worded. After hearing how she sounded, the employee realized that she needed to say more than just a curt "yes" or "no" when answering a patient's questions.

If rudeness is an ongoing issue, the employee goes through another customer service training session. If more than three customer complaints are received, a corrective action process is used.

"We have a telephone etiquette training program that the employee will attend. We also have a 'Commitment to Service' training program and a refresher course," says Milheim.

All new access employees must attend the day-long commitment-to-service session. The refresher course is attended by employees every other year and is used as a supplemental program when needed. "Role playing is a large part of the program. By providing employees with the proper tools, we can ensure that both the employee and patient have beneficial encounters," says Milheim.

Role-playing is first done when a new employee is hired, during the eight-hour customer service training program. The new hire interacts with "patients" who are nervous or angry about various situations. Each year, employees attend a four-hour refresher course, which covers role-playing.

To come up with the role-playing situations, patient access trainers asked front-end staff to share some tough situations. For example, one scenario involves a patient who has come in as a direct admit and is waiting for a bed. The patient thinks it is taking much too long and becomes irate with staff.

For situations like this, staff rely on an "aggressive behavior" policy that outlines how to deal with abusive, angry patients, she says. The staff are able to set boundaries and inform patients of expectations for acceptable behavior. "But by doing regular quality assurance with phone calls, we hope to identify those situations before a patient complains," says Milheim.

At Intermountain Health Care in Salt Lake City, UT, quality review measures have been established for all patient access staff. "To mention a few, we quality review the accuracy of demographics, use of scripting, and documentation in account notes," says **Denise Slane**, director of patient access. "We also monitor financial requirements, payment arrangements, collections, and referral to eligibility staff for Medicaid screening or financial assistance."

To be sure staff are complying with all of these measures, telephone monitoring is done for pre-registration call centers. All calls are recorded.

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"We monitor five calls per registrar monthly for those meeting standards and five biweekly for those who are not yet meeting standards," says Slane. "The recordings are applied to our quality standards. This ensures we are meeting both customer service goals and our database requirements."

By monitoring the calls, Slane says, "we have been able to recognize some incredible staff interactions with our patients."

On one occasion, an employee was pre-registering a patient who was scheduled for an invasive procedure. During the conversation, she also estimated the cost of the procedure, established payment arrangements, provided way-finding information to the patient, and reassured the patient, stating, "You are in very good hands. Take care of yourself. Hope you feel better soon."

When an interaction like this is heard, the example is held up as a training tool at monthly staff meetings. On the other hand, if staff interactions are not appropriate, the recorded call is played for the staff member. Examples of how the conversation should have been handled are shared.

"If the employee needs additional training to better understand our process, this training is arranged at this time," says Slane. "We have also recognized problems with our scripting and have been able to make adjustments."

On a monthly basis, supervisors share these quality results with individual staff members. Anyone who isn't meeting the department's goals is given additional training on recommended scripting to be used during the pre-registration process.

"We also provide a mentor for new employees. The mentor actually sits with the new staff member for one or two weeks," says Slane. "In addition, all of our training materials are available to staff at all times via our online training tool."

A pay-for-performance incentive program was recently introduced. If employees exceed quality and performance measures, they receive incentive pay on the first pay period of the following month. "Our staff have been very receptive to both our quality measures and the incentive program," says Slane. "Staff morale has improved. No longer are the poor performers compensated at the same level as those exceeding quality and productivity standards."

• Ask patients directly.

At Oshkosh, WI-based Mercy Medical Center, the patient access department does a "Secret Shopper survey." "Our receptionist is in charge of deciding whom to hand out the survey to. It's a great way to see in 'real time' what the public truly thinks," says **Linda Swanson**, registration coordinator. "Plus, it makes the patient feel special that they have been picked to do so. We haven't had a particular staff person mentioned as doing something wrong, but we have had patients mention staff people by name who went above and beyond."

Surveys are handed out randomly to patients about five times a month. "The survey is short and sweet. Otherwise, patients don't like to fill them out," says Swanson. Just two questions are asked:

• Did you have any trouble with parking or locating patient access?

• Is there anything about your registration experience you would like to comment on?

"We've found and resolved issues that we didn't know we had," says Swanson. For example, patients reported problems with finding handicapped parking spots, and patients with hip or knee replacements wanted higher chairs. Both of these concerns were addressed.

"If the patient is willing to put their name and phone number on the form, we will call to let them know their concern was addressed," says Swanson. "Even if we get complaints, we always follow up with the patient and staff, too, so they are aware of what caused the issue and resolution."

• Have higher-ups shadow staff and provide feedback.

About a year ago, Lennen presented her staff with a program called "Give 'Em the Pickle." This drove home the importance of showing customers that they are the most important people in the world at that moment. "This in-service worked very well for the staff. My immediate director and vice president sat in on this as well," she says.

The concept of the presentation, says Lennen, was "why should it matter if someone gets an extra pickle? If that is what is needed, just give it to them. Some people get so hung up on not giving people what they want, for fear that it will be reflected on them that they gave something away."

Access staff were told to treat every patient as if he or she is the only person in the world when standing in front of you. "Even more, if they got something the last time they were at your facility, they will expect it the next time. So it's also important to be consistent in what you do and say," says Lennen.

Shortly after the presentation, the hospital's

CEO spent about four hours in the patient access department, shadowing staff through the outpatient, inpatient, and emergency department processes. "He wanted to see our interaction with patients and families. He was especially complimentary on how well the staff engaged in conversation and related to the patients and their families," says Lennen. "The 'pickle' teachings work very well here."

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Use 'visual audits' as coaching opportunities

"Customer service is something that is sometimes really hard to monitor," says **Linda Smith**, manager of patient registration and centralized scheduling at Barnes-Jewish St. Peters (MO) Hospital. "Unless you have direct interaction with staff, you don't always know. Typically, you can train someone for the necessary job skills, but that customer service piece has got to be there."

For this reason, Smith makes a point of doing frequent "visual audits" where she listens to staff talking with patients. "These audits are based on a requirement that we have committed to with our revenue cycle team. We ensure that our financial brochure is given to each patient. Staff make them aware of financial assistance they might be eligible for, using the correct scripting," says Smith.

Emergency department registrars also are audited to make sure they are asking for copays at the point of discharge.

"The audits are used as coaching opportunities. It also gives the employee some time to interact with his or her supervisor," says Smith. "Staff know they are being audited and understand why — so we can be sure we are delivering the information we are required to give. It is a good way to touch base with staff once a month."

Although "secret shoppers" aren't used, staff are encouraged to think of every patient encounter as a potential "secret shopper." "It may be an employee who works for the hospital, for example. And I guarantee if they do not receive good customer service, they will call me," says Smith. "They may be people who actually work here who know what the process should be, and they will give you feedback."

With this in mind, Smith tells her staff, "If you treat everyone with great customer service, and follow our process each and every time, there's really nothing to be concerned about."

Access staff are trained with the AIDET tool, standing for:

- acknowledge the patient;
- introduce yourself;
- duration;
- explanation;
- thank the patient.

"You don't want to sound as if you're saying the same thing over and over without any type of enthusiasm, but scripting can help staff to remember that the patient needs to be acknowledged," says Smith. The AIDET scripting would sound something like this: "Hi, my name is Linda and I'm going to be completing your registration today. This is going to take us about three or four minutes. Then you will go straight to the lab and they will take care of you. Thank you for choosing us for your service."

Smith says that although the patient access services are decentralized, her office is in the admitting department. Therefore, she can easily hear the tone of voice and comments made by employees. "Some of our long-term employees have that really strong knack for customer service. They make each patient feel that they are the only person they talk to today," she says. "A family member once surprised everyone by bringing a bouquet of flowers to a registrar to thank her for her service."

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Don't miss a chance to collect

Do you have the technology, processes you need?

Lack of the right technology to automate time-consuming, error-prone processes can put patient access departments at a big disadvantage. On the other hand, there is a concern that some technology investments may be a waste of money, particularly when all expenditures are being put under the microscope.

"Collecting cash at the point of service is not the taboo topic it once was," says **Ron Camejo**, director of revenue cycle practice at Chadds Ford, PA-based IMA Consulting. "This is partly due to a growing realization of the importance of upfront collections to an organization's bottom line, and partly due to the emergence of technology 'accelerators' that are simplifying the once-onerous task."

After implementing stand-alone applications, some patient access department are seeing impressive results. However, Camejo says when these are implemented as "components of a well-considered revenue cycle vision, the overall results can be greater than the sum of individual parts."

John Woerly, RHIA, CHAM, a senior manager at Accenture in Indianapolis, says that these technologies should be considered by patient access leaders in order of importance:

- insurance eligibility/benefit verification tools;
- an online benefits engine, which ties employer/payer information to managed care contracting;
- patient liability estimation tools;
- point-of-service collection tools;
- propensity to collect/credit scoring tools;
- online outstationed Medicaid eligibility screening;
- application production tools, online charity application screening, and application production tools.

"Potential technology disasters include non-integrated, stand-alone systems — systems that have limited payer connectivity, poor vendor implementation planning, and [are] not fully monitoring outcomes," says Woerly. "You need to be looking at results on a daily basis and reporting and tracking results."

Woerly says planning, training, and monitoring are the ways to avoid these pitfalls. "Measure current outcomes with denials, upfront collections, the number of Medicaid referrals and approvals, and number of charity cases approved," he says. "Know the full cost of the system change, including the impact on staffing, and the per-transaction cost vs. an annual flat rate."

Don't depend on vendors

Kristi Heussy, revenue and billing system manager at Virginia Mason Medical Center in Seattle, says that when reviewing a potential technology investment, she answers these questions: Will it fit with our flow? Will it benefit our patients? Will it give a good return on investment?

Heussy says that one mistake is to place too much dependence on an outside vendor, instead of working as partners. "The key for partnering is making sure you and the vendor have the same vision for what constitutes a good outcome," she says. For example, if a vendor is tasked with completing a coverage application for a patient, for them a good outcome is getting that work done. For the medical center, though, the good outcome is getting the patient coverage so that he or she may get safe, effective treatment and discharge, as well as payment for services provided.

Before investing in any patient access technology, Heussy says that you must do some upfront work in your department, as follows:

- **Involve staff in improvement work, such as eliminating waste and improving flow.**
- **Understand who your upstream and downstream customers are.** "Interview all parties to determine who is a customer of the service to ensure every aspect of the work is covered and sequenced," says Heussy. "Do not depend on a vendor to solve a problem that is deeply embedded in the flow of information in the hospital."
- **When talking with other users, ask detailed questions about the format of electronic information being returned.**
- **Take the time to do site visits of the vendor's other customers.** "It's helpful to see how other customers are using the product successfully," says Heussy.

A. James Bender, MD, Virginia Mason's medical director of health information, says, "Access, and the systems that support it, need to be focused on the patient's needs, and efficiently gathering the clinical, social, referral, and financial information that is needed for timely care and defect-free billing. The goals are seamless integration, first call resolve, and high reliability."

The information gathered at the time of a request for service is a "set up" for closure of the encounter. "The ideal system prompts the capture of information as data in a 'reusable' format as we build the patient's story. We avoid the waste and errors of duplication and then present this information where it is needed throughout the episode of care," says Bender. "In our vision, care begins at the request for service and ends when the medical interaction is complete and the bill is paid."

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Revamp access with these 10 technologies

"A number of exciting collection technologies have evolved over the last few years. They are already lowering costs and improving services," says **John Thompson**, senior consulting manager at Chadds Ford, PA-based IMA Consulting. Here, he gives his "top 10 list" of patient access technologies:

1. Contact verification.

In addition to improving billing and statement delivery, this can also increase staff productivity. "Optional batch features are often offered," says Thompson.

2. Eligibility verification.

Coverage benefits can be verified prior to service delivery by submitting patient information and receiving a real-time response. "Rejections and denials are reduced, and upfront collections are increased," says Thompson. While old approaches for web site and telephone verification weren't integrated, key features to look for now include normalized benefit formats with the ability to design "standard" and "detailed" benefit screens, and ADT/practice management system integration.

3. Patient payment estimation.

These systems can reduce bad debt, accelerate payments, and cut collection costs. Previously, staff collected only copayments and self-pay deposits, and these were based on "guesstimates rather than estimates," says Thompson. New systems have charge master/eligibility system integration, with the ability to apply benefits to real charges, and charge master/contract management integration, with the ability to apply contractual allowances before developing estimates.

4. Communication management.

Having electronic records of payer communications can increase productivity, reduce denials, and increase successful appeals. Thompson says that features to look for include the ability to automate and monitor calls, and manage inbound and outbound faxed documents and e-mails.

5. Propensity-to-pay scoring.

This streamlines self-pay approvals while proactively identifying the need for financial assistance, instead of subjective approvals done by financial counseling staff. "This resulted in understated charity care on financial sources," says Thompson. New systems are able to factor in self-pay funding sources, such as available credit on credit cards, lines of credit and home equity, and external finance solutions offered by banks and other lenders.

Thompson says two good features are segmentation analysis, which customizes scoring profiles to community characteristics, and workflow management, which electronically forwards accounts to the financial counseling process.

6. Electronic cashiering.

This can accelerate collections by increasing the speed of payment capture, save time by automating manual payment posting, and increase efficiency by enabling more employees to accept payments. "It also provides dashboard reporting of payment activity, with the ability to track, audit, and control all customer payments," says Thompson. Instead of collecting payments only at the time of service, these can be accepted real-time from any location, including web portals. Thompson says to look for a system that accepts all forms of electronic payment and does cash posting and management so that payments can be audited, tracked, and controlled.

7. Financial assistance automation.

A patient's eligibility for entitlement programs is proactively identified, which reduces unnecessary outsourcing to self-pay vendors and cumbersome manual processes. Systems can pre-populate applications for Medicaid with information from your ADT system. "Look for integration with propensity-to-pay systems and e-pay systems, and presumptive eligibility and approvals," says

Thompson.

8. Rule-based document imaging.

These systems can reduce time-consuming copying and scanning, and there are fewer denials related to missing referral or authorization forms. "Optical character recognition mapping compares insurance card information to ADT system fields and corrects data entry errors," says Thompson.

9. Patient self-service kiosks.

These can reduce wait times and decrease errors due to inconsistent collection compliance. Thompson says to look for a system with date/time stamping of arrival, automated printing of armbands, and real-time payment processing and eligibility verification.

10. Rule-based process automation.

"Efficiency can be vastly increased, cash flow and collections improved, and whole categories of errors eliminated," says Thompson. "Look for full integration between all applications." ■

Some staff perks cost you next to nothing

Giving huge raises and promotions to every access staff member is one way to boost morale but isn't financially feasible. However, some attention-getting "perks" cost little, if anything. "It is amazing what a pat on the back does for folks," says **Jackie Mitchler**, revenue cycle analyst in the patient business services department at Affinity Health System in Menasha, WI. Here are four proven strategies:

• Give out gift cards in small amounts.

If an access staff person goes "above and beyond," Mitchler does these things:

• Staff get to choose a $5 gift card.

• A "Star" balloon is placed in the employee's cubby.

• The employee is praised at the next department meeting.

• Get a contest going.

"If you get a little competitive game going among the staff, you would be surprised at what they can do," says Mitchler. Affinity's department spotlights a top copay collector for three consecutive months. Currently, the top copay collector is a registrar in the emergency department who typically collects close to $2,000 per month just in copays. This employee received a pair of movie tickets and a popcorn gift card.

• Put employees' names in print.

Affinity's patient access managers send in "kudos" congratulating staff members who went above and beyond. These kudos are featured in the organization's weekly newsletter. "This weekly newsletter goes out to the entire senior staff, so this praises your staff's glory throughout the entire organization," says Mitchler.

• Talk about impressive employees in meetings.

Helen Contreraz, manager of patient access services at University of California-Los Angeles Medical Center, says that in addition to publishing the successes of access staff members in the hospital's newsletter, "at the senior leadership level, we quantify the success in our in-house review meetings."

• Send a thank you.

At Rex Healthcare in Raleigh, NC, when patient access staff collect on high-dollar accounts, in addition to receiving a pay-for-performance monthly bonus, the CFO personally sends them a "thank you" in recognition of their contribution. "Our management team simply sends an e-mail to the CFO to alert her of our top collectors for the prior month," says **Joe Palumbo**, CAM, CHAA, manager of patient access site administration. "Our CFO takes the time to write a personal note, which is then delivered to the staff from their manager."

These employees also receive praise from the CEO during quarterly co-worker forums. Recently, intake specialists in central registration were given recognition for their year-to-date collections. "They receive this praise in front of 20 to 50 hospital co-workers who are gathered for each forum, which are scheduled daily for a two-week period," says Palumbo. "Some of our staff have also been featured in the organization's monthly newsletter. This is available for all to see through our hospital's internal web site."

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Team up with clinical areas to improve satisfaction

Are patients complaining that they're waiting too long? Don't forget that clinical areas are closely connected to this common complaint.

Helen Contreraz, manager of patient access services at University of California-Los Angeles Medical Center, recommends having clinical departments survey patients about issues involving access. "The organization has taken a view that good customer services starts in access. That sets the tone for the rest of the patient's stay," she says.

In additional to national Press Ganey surveys, the access department does its own independent surveys in conjunction with various clinical partners. "We do this with customers who are very engaged with us, to make sure we are delivering superb customer satisfaction," says Contreraz. "With the OR and the ED, we meet regularly to talk about how our performance is."

In turn, those clinical areas survey patients about their experience with access. For example, patients are asked about their admission experience, how easy it was to find registration, whether someone called them before their appointment, the courtesy of staff members, how organized staff were, and overall satisfaction.

"Through that process, many patients will name individual employees. That gives us the opportunity to recognize certain individuals who demonstrate excellent service," Contreraz says. "This is done by the COO, who sends out a broadcast to praise that employee. For the past six quarters, access has scored in the 99th percentile out of 600 patient responses."

Recently, the patient access department worked on a performance improvement project with the operating room. The goal was to ensure that cases started on time. "That starts with us," says Contreraz. "So we worked on improving parking and signage."

Working together, it was identified that the hospital's parking kiosks didn't open early enough. "Just 30 minutes made a huge difference, since cars were lining up and waiting for the parking kiosks to open. In turn, that made our patients late in arriving to us, and it was a domino effect," says Contreraz.

Each week, patient access compares check-in data for OR first cases with the OR's data. "We discovered differences in our clocks, as well, and now we are measuring the same way," says Contreraz. "Even one minute late is counted."

Patient access realized that it needed to allow time for patients to get from the registration area to the OR, in order to meet the start time goal. For its part, the OR identified that the clinical check-in area needed to start 15 minutes earlier.

In addition to this ongoing collaboration, "the patient experience" is a topic at every access staff meeting. "Every quarter, we go through our performance," says Contreraz. "We talk about the tone of voice we use, the words being spoken, and our body language."

These are things that Contreraz looks for during rounds at the hospital, which are done with the rest of the management team one hour a week. "Staff are directly observed for their interactions with patients," she says. "We always give them feedback, whether good or bad." For instance, one employee was told that she seemed friendly enough but didn't make eye contact with patients.

Team approach is taken

At North Carolina Baptist Hospital, the outpatient clinics have a unique reporting structure, with one nurse manager responsible for both patient access and clinical staff. This unified management structure allows for a team approach to setting standards, problem solving, improving patient satisfaction, improving clinic flow, reducing waste, and improving communication.

"Our clinics do more than pay 'lip service' to the team concept between patient access and clinical staff," says **Jo Anna Gresham**, MSN, MHA, CMSRN, RN, associate director of the outpatient department.

"Because we have open lines of communication now, issues are dealt with as they come up. This makes everything flow smoother and everyone happier," says **Sheila Stevens,** RN, adult medicine nurse manager. "We are able to brainstorm together and much more productively since we have so many minds to work with now."

When nursing and registration were first merged, however, there was a need to "narrow the division" between the two areas. "Even though their work was parallel, they rarely interacted with one another and consequently did not really 'know' each other," says Stevens.

A monthly meeting time was established to discuss shared issues and ways to resolve them.

"Before we could get to that level, though, we needed to recognize and respect each other as individuals and contributing members of the team," says Stevens.

Before the first meeting, Stevens interviewed all the members of the team regarding likes, dislikes, hobbies, and accomplishments. "I then made a sheet of all these facts mixed up without names attached. The meeting was a 'party' where everyone mingled, asking each other questions to try to match up people with facts," says Stevens. "The person with the most correct answers at the end of the meeting was awarded a prize. It was a great way to get to know one another."

After that, a portion of time in each meeting was devoted to team quality, such as adaptability, collaboration, commitment, or enthusiasm. "The quality is presented jointly by a member of nursing and registration," says Stevens. "These two were paired by drawing names, so that they had to work with someone that they didn't necessarily know that well."

Issues are now routinely brought up during meetings, and staff enjoy working them out together. One example is that too many patients were knocking on the door for information.

"This had been a point of discontent between the two areas, with nursing thinking, 'Registration sends everybody to the door to keep from dealing with them,' and registration thinking, 'Nursing won't help anybody with anything! They just keep sending them to us,'" says Stevens.

By talking the issue out, each area could understand the frustrations of the other. A solution was developed to help patients meet their needs. First, the underlying reasons that brought patients to the door were identified. Next, scripts for what patients should be told were developed.

"This enabled the registration folks to know what patients needed to be told to help resolve their problems, and helped nursing understand that if a patient came to the door they had more than likely bypassed registration," says Stevens.

All members of the team participate in the shared governance process as well as in implementing the organization's model of care — "relationship-based care."

"These are the venues that we use to identify problems and find creative, team-driven, patient-centered solutions," says Gresham.

Clinical surveys done at North Carolina Baptist assess patients' level of satisfaction with their entire experience, including access. "Patient access is the patient's first level of communication, whether by phone or in person," says **Monica T. Brown**, MPH, manager of the outpatient department. "If we are to have an accurate picture of our strengths and areas for improvement, we must start at the beginning of service delivery — patient access."

Prior to January 2010, an internal survey was used to measure patient satisfaction. Now a Press Ganey tool is used, with questions listed in the same order as a patient's visit progresses. "This way, even if the patient does not know whether it is an access or clinical issue, we are able to determine the appropriate area," says Brown.

One area of patient dissatisfaction that involves patient access as well as clinical staff is wait times. "These are the two groups of people that stand between the patient and the provider," says Brown. "Due to the necessary tasks that must be performed by both patient access and clinical staff, the groups may be perceived as barriers to the patient whose goal is to interact directly with his/her provider."

Early in 2009, patients were complaining to their providers that they were waiting a very long time to complete their registration. "A provider investigated the process and found that our current process was not very efficient and created dissatisfaction," says Brown. "We were having the patients sign in, have a seat, then be called back to complete their registration. Now, patients stand behind a designated sign and wait for the next available registration representative. Patients are much happier with this process."

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Work with clinicians for collection of ED copays

Of all hospital areas, emergency departments are probably the most problematic when it comes to collections. Not only do patients want to leave as quickly as possible, federal law prevents you from collecting anything before a medical screening examination is completed.

Linda Swanson, registration coordinator at

Oshkosh, WI-based Mercy Medical Center, says that when her department first started collecting ED copays, "staff were nervous and uncomfortable asking for these." At a department meeting, staff were coached on how to ask for copays by a guest speaker from a collection agency.

Staff began to realize, says Swanson, that "it truly boils down to how you ask and the tone of voice you use. Also, you need a good working relationship with your ER, so you can work together to ensure all patients are seen by registration prior to leaving."

The ED has switched to bedside registration, so access staff use this to their advantage. "We work with the ER staff to see the patient after the doctor has seen them and they are waiting for tests to be done," says Swanson. "We also do the ER copays at that time. So when the patient has been given their discharge instructions from the ER, they are truly complete for registration as well, and there are no delays to pay."

An electronic board displays the patients currently in ED treatment rooms so access staff can keep track of this information. Conversely, ED staff can tell at a glance whether their patient was already seen by access staff, if the tracking board indicates that "long-form registration is complete."

Linda Smith, manager of patient registration and centralized scheduling at Barnes-Jewish St. Peters (MO) Hospital, says, "When our department began collecting ED copays, the question, 'What makes us successful?' was asked.

"Is it how much money we collect, or is it what percentage we collect?" asks Smith. "Here is where we landed: If Mary registered 20 people in a day, how many could she have potentially collected from?" For example, if an ED patient is admitted to the hospital, has a high acuity, or is a workers' compensation case, copays are not collected. Therefore, of the 20 registered patients, perhaps only 10 were candidates for copay collection.

A spreadsheet was created for each access staff member that tracks total possible collections and the amount actually collected. Top-percentage collectors are recognized with verbal praise, meal tickets, and sent congratulatory e-mails. Previously, a staff member might have been recognized for collecting $2,000, but that figure might not be as impressive if the individual could potentially have collected $9,500.

In addition, the department set a goal to collect 40% of total possible collections. "We post our total collections daily so staff can see our challenge for that month. Now that they know what our goal is, we have seen significant gains in our collection," Smith says.

One challenge for registrars was asking a patient for the copay, as they just didn't feel comfortable doing this. Staff were trained on the appropriate way to ask and, also, when it needs to wait until a later time.

"More ED patients are experiencing greater out-of-pocket expenses and deductibles. We see more and more companies going to a higher out-of-pocket for their employees. They may have had an 80/20 plan, and now they have a 70/30, or a much higher deductible for hospitalization," says Smith. "Our access staff ensure that patients receive information about financial assistance available through the hospital. Our goal is to make sure that all patients are educated about this assistance."

Collecting in the ED is a "huge balancing act," says Smith. "We have to be sensitive to our patients and care for their needs first and foremost." ■

Take action if you receive a complaint

Stay visible and accessible

At times, patient access bears the brunt of many complaints. Some are justified; others are not. But either way, your response should be immediate.

"It is important for access leaders to be as visible and accessible as possible throughout their departments," says **Cheryl Webster**, director of patient registration services at William Beaumont Hospital in Royal Oak, MI. "This availability will allow your staff, as well as staff from other departments, to address issues early before small issues become big problems."

When a problem is brought forward, your first step should be to research it. Obtain as much information as possible, such as interviews with staff, service-related statistics, individual patient accounts, and any other available data.

"Sometimes the initial information is incorrect. Once the manager gathers the factual data, a clear picture of the true problem emerges," says Webster. A patient may report that he or she received a "bill

from the hospital," when in fact, the patient is referring to an explanation of benefits sent by the insurance company. In reality, the outstanding amount already has been billed to a secondary insurer or is in the process of being appealed.

Similarly, if a patient reports "waiting a long time for registration," it may be that the long wait occurred in the doctor's office before the patient arrived at the hospital.

"If a computer system is involved in the error, the investigation should include a re-creation of the problem to help locate the initial cause," says Webster. "Capture screen shots also to help demonstrate to others, if necessary." She gives these examples:

- screen shots of the data as they were documented accurately;
- specific information that may have been entered in error;
- specific times of visit arrival, phone numbers, or other data in question;
- an audit trail showing who actually input erroneous information, and when.

Webster says that whenever she finds that another department has made an untrue accusation, she brings it to the leader's attention in a private discussion, either by phone or in person. After the situation is discussed, she then works with the manager to determine the best way to clear up the misunderstanding with all of the individuals who were misinformed.

"We all make mistakes, and I do not want to embarrass anyone. Sometimes it is difficult not to be defensive, but I work very hard to overcome the temptation to point fingers or make sweeping negative comments, as the other side only has half of the story," says Webster. "Mostly I try to treat them in the same way that I like to be treated."

One way to clear up misunderstandings is to send a clarifying e-mail, or explain the situation verbally in a meeting so it is documented in the minutes.

As the patient access department often is an "easy target for blame," Webster recommends taking these proactive steps:

- **Make everyone aware of what you expect.**

Webster says that, in particular, staff should be aware of these expectations:

- wait-time standards and what to do when the threshold is reached;
- how to handle specific patient concerns, how to respond, and who to call;
- scripting to follow to properly communicate legal requirements to patients and reduce misunderstanding and potential complaints;
- technical accuracy, as these errors flow to other areas, such as clinical areas and billing.

- **Stay connected to the front line.**

"In several key areas of my department, the staff send an e-mail to their supervisor and me at the end of the shift to let us know of any problems that occurred so that we can follow up appropriately," says Webster. Staff are required to report any customer service concerns to their supervisor, even if they are resolved, so that service recovery can be initiated, follow-up can be done, and appropriate people can be notified.

- **Hold regular meetings with key departments to facilitate a positive working relationship.**

"Staff can also be included if appropriate for the situation," says Webster.

A few years ago, the department noticed there were several service concerns from patients at one of the hospital's sites. The customer service survey scores also were the lowest in the hospital.

"The clinical manager and I met together with staff from both areas. We were very blunt about our expectations to work together and give the best possible service to our patients," says Webster.

They explained that the goal was to see the service score for the entire area increase to be comparable with other sites. "We wanted to replace finger pointing with teamwork and focus on our patients." says Webster. "The clinical manager and I set the tone by talking to them together and asked for their ideas for improvement. Today, this area is strong, their service scores are among the highest, and the staff show pride in their whole team."

- **Round frequently to be sure that patient flow is moving along and any delays are being handled effectively.**

"Keep wait-time and other service-related metrics to measure success. Data are always helpful to

COMING IN FUTURE MONTHS

- Reduce bad debt by automating financial assistance
- Prepare staff for the very worst customer situations
- Revamp your processes for monitoring outcomes
- Work with clinical areas to dramatically reduce wait times

establish credibility," says Webster.

Encourage staff to bring problems forward quickly as they are observed.

When made aware of a negative situation of any kind, such as a staffing glitch that resulted in longer-than-acceptable wait times, Webster connects with managers from affected areas so they hear about the problem early and directly.

"They are made aware of what has been done to resolve the issue," says Webster. "If the problem stems from staff in another department, I let the manager know what happened but refrain from editorial comments, such as saying, 'My staff would never do this,' no matter how tempting it may be. Another department may not understand why an event occurred. They only know what they saw in one moment of time."

A registrar might have been working with a doctor's office on obtaining an authorization, and talked to the patient in advance about the problem. "The other department only sees that a patient is upset, and assumes that the access department did not do everything possible to assure the patient's experience was positive," says Webster. "Or, maybe the patient forgot their written order and we are working to get another copy. We are doing everything possible, but the department just sees a waiting patient."

• Audit crucial activities to identify human and process errors so that they can be corrected before they create complaints.

If there are consistent problems with orders or medical necessity causing patients to wait on the day of service, for example, you may need to work with the doctor's office. "They may have a new staff member or some other type of change. Or, if it is one of our staff who is making frequent errors, they may need more education," says Webster. "It is imperative to be on top of problems and put corrections in place early."

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