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July 2010: Vol. 29, No. 7
Pages 73-84

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Zero in on whether people are *really* satisfied with your access department

'All or nothing' questions aren't enough

If patients report being "very dissatisfied" with the admission process, does that mean they're angry because a registrar was rude and unfriendly? Or was it because they waited hours in the emergency department hallway for an inpatient bed to become available?

Without getting the specifics from that patient, you'll never know. This missing piece of information may prove very costly if your department gets tagged with an undeserved reputation for providing bad customer service.

One problem is that hospital satisfaction surveys often are too general in what they ask and fail to address patient access in particular. "Most satisfaction results do not focus specifically on the functions of the access/registration staff, even though staff are often measured on those results," says **Jeanette Foulk,** director of admitting/discharge at Methodist Charlton Medical Center in Dallas. "Often, the registration piece is only a small part of the survey question."

Although inpatient surveys at Methodist Charlton do cover the admission process, the questions don't break down the underlying reasons for delays.

A patient may be very unhappy about waiting several hours for bed availability. Yet that same patient may, in fact, be very happy that the registration process was completed in only 10 minutes. Regardless of that, the patient probably would report dissatisfaction with the admission process. "The survey does not make allowances for other variables in the process. It is an 'all or nothing' question," says Foulk.

Clearly, survey responses often are difficult to trace back to specific patient access processes. One reason is that among organizations there are varied structures and functions of registration.

"Multidisciplinary work units, decentralized registration models, and the complexity of patient access functions related to scheduling, pre-registration, and insurance verification are inconsistent industrywide," notes

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Michael F. Sciarabba, MPH, CHAM, director of patient access services at Advocate Illinois Masonic Medical Center. "These processes all have associated survey questions, but interpretation of the question and function is inconsistent and frequently misunderstood by patients."

Department-specific patient satisfaction surveys are a much better measure of satisfaction with access. (**See sample patient satisfaction survey used by one access department, page 75.**)

For this reason, Methodist Charlton's access department has developed a process involving volunteers rounding on the floors. These individuals, mainly retirees from the community, are given a questionnaire tool to assist them.

The volunteers ask patients these questions:

- Would you rate the friendliness of the access/registration staff as very good? If no, please explain.
- Would you rate the ease of the registration process at the time of admission as very good? If no, please explain.
- Would you rate the timeliness of bed availability during your admission as very good? If no, please explain.

"I am hoping these questions will assist in narrowing down dissatisfaction in registration," says Foulk. "The patient satisfaction results may be truly a registration/access issue, or may be a bed availability issue. Right now it is of no use to us, because the focus is not on the correct reason for the dissatisfaction."

No matter how frequently satisfaction is measured, vague data are not useful, Foulk says. On the other hand, if you can come up with valid data showing that patients are satisfied, don't hesitate to share them.

"I would suggest quarterly reports to senior leadership focusing on access successes, along with goals to assure the continuation of those successes," says Foulk. "Also, provide an action plan for those areas that need improvement."

If patients aren't happy with something access is doing, that's important to address. However, there are also going to be areas in which patients are very satisfied. You don't want to miss the good news, either.

"Focus your surveys on the helpfulness and courtesy of the patient access staff, instead of focusing on the entire admissions experience," suggests Foulk. "Include other departments in the admissions process, such as ED admissions, surgery patients, and bed control."

Unfair criticism

Another challenge is that patient access staff members frequently spend time on "behind-the-scenes" tasks. Many processes involving patients, physicians, ancillary staff, and payers are not measured by surveys. "These informal encounters can be quite extensive and have a large impact on resources in the operation," adds Sciarabba.

The difficulties of coordinating the patient's test and treatment, and meeting all organizational, compliance, and payer requirements are often invisible to patients.

"Patient access departments depend on many

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

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Downtown Health Plaza of Baptist Hospital Patient Satisfaction Survey

1. How did you make today's appointment?
   - ☐ scheduled at last appointment
   - ☐ another doctor's office scheduled the appointment
   - ☐ I called to schedule the appointment
   - ☐ other, please specify:_____

2. When your appointment was scheduled: (Please check one of the following)

	Agree	Neither Agree nor Disagree	Disagree
A. Was your call answered in a timely fashion?	☐	☐	☐
B. Was the staff professional & helpful?	☐	☐	☐
C. If you left a message, did you receive a return call within 2 days?	☐	☐	☐
D. Was there an appointment available in a reasonable period of time?	☐	☐	☐

3. Please rate the friendliness & courtesy of our staff. (Please check one of the following)

	Good	Fair	Poor
Check-In Staff	☐	☐	☐
Nursing Staff	☐	☐	☐
Check-Out Staff	☐	☐	☐

4. Rate the care you received from the physician or other provider who saw you today.

Good	Fair	Poor
☐	☐	☐

5. Please rate the comfort & cleanliness of our building during your visit.

	Good	Fair	Poor
Lobby/Waiting Area	☐	☐	☐
Exam Room	☐	☐	☐
Bathrooms	☐	☐	☐

6. How likely are you to return to our clinic?
☐ Unlikely ☐ Not Sure ☐ Likely

7. Would you recommend our clinic to your family/friends? ☐ YES ☐ NO

8. What can we do to improve your next visit?
_____
_____
_____
_____

Source: North Carolina Baptist Hospital

sources to ensure a seamless process for the patient," says Sciarabba. Physicians, insurance companies, governmental agencies, and ancillary clinical departments all have a direct impact on the access of care to patients.

One of the primary roles of patient access is the coordination of all of these components. The result is efficient access.

"When there are challenges in coordinating these required components, many patients perceive patient access to be responsible," says Sciarabba. "These issues may or may not be directly linked to the department."

Regardless of any obstacles it faces, though, Sciarabba says it is still the role of patient access to do all it "can to coordinate the care, remove barriers, and communicate clearly with the patient so their expectations are met."

Tweak survey questions

At Emory University Hospital Midtown in Atlanta, a hospitalwide survey includes questions related to the speed of admission and the preregistration process for inpatients. For emergency department patients, there are questions related to

arrival and personal/insurance information.

The "speed of admission" question, however, may result in misleading information because the majority of scheduled patients are pre-registered. On the day of arrival, they are able to bypass registration areas and report directly to their point-of service area.

Since the general "admissions" questions cover all areas, it's hard to determine if responses are related to a specific admissions area or another "check-in" point of the hospital.

"From a patient's perspective, the point-of-service area may be considered 'admissions' when, in reality, it is not," says **Elease Brown**, assistant director of patient financial services. "Thus, scores may not be reflective of our specific admissions areas. If the wait times were particularly long — or short — the appropriate area may not receive the feedback."

At Greater Baltimore Medical Center, Press-Ganey surveys are used to assess patient satisfaction. "We found that some of the initial questions associated with the survey as related to patient access were worded or structured in such a way that was causing us to be scored or rated on elements that were not entirely in our span of control," says **Duke Bowen**, BS, CHAM, associate director of patient access.

One of the questions associated with patient access asks patients to rate the speed of the admission process. "Certainly, we were involved in upgrading the accounts to an 'admitted' status. But we were not in control of many of the other elements that could cause delays in admission," says Bowen.

Beds might not be immediately available to admitted patients because other inpatients are waiting for discharge orders, or environmental services might be unavailable to clean the room.

"The structure of questions on the surveys are not entirely in our control, as the survey questions are standardized via Press-Ganey for benchmarking and comparison purposes," notes Bowen. "After some negotiations with our service excellence department, we were able to successfully present our rationale."

Eventually, the wording of the survey question was changed; patients now are asked to rate the "waiting time to register." "The other survey questions are generally related to 'courtesy' or 'helpfulness' of the patient access staff," says Bowen.

Patients need to ID staff

There may be confusion because the patient is unable to identify patient access staff. "Ideally, we want to minimize the impact of especially negative survey comments or ratings if they, in fact, are related to hospital staff not associated with patient access," says Bowen. "Therefore, we have implemented patient access uniform requirements, which clearly identify our patient access representatives."

The department has considered implementing its own customized patient access surveys or questionnaires. "But, we have decided for the time being that the standardized Press-Ganey surveys are providing sufficient and appropriate feedback," says Bowen.

The department hasn't identified a need to measure satisfaction or dissatisfaction with its "internal" departmental customers. This is because there is a constant flow of both positive and negative feedback from co-workers and other departments.

"The lines of communication are wide open," says Bowen. "We pride ourselves on our responsiveness as related to these comments or complaints."

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Survey says: Give staff recognition

If a satisfaction survey includes any positive feedback about an access employee at Greater Baltimore Medical Center, this does not go unnoticed.

Any positive comments are passed along directly to the appropriate employee, and a recognition system is in place. Employees receive a personal letter of thanks from the hospital's CFO and are recognized in the "Kudos" section of the monthly patient access newsletter.

Monthly satisfaction scores and goals are reviewed with all department employees. Patient access supervisors also receive the detailed results of the various surveys. "They are responsible for researching every comment and every account listed," says **Duke Bowen**, BS, CHAM, associate director of patient access. The goal is to recognize individuals for exemplary service, offer any necessary coaching or training, or provide disciplinary action if warranted.

Use separate surveys

"We are lucky that currently we have surveys that are associated with separate and distinct hospital services," says Bowen. "Therefore, we are generally able to match up the feedback with the particular patient access registration points."

Currently, separate surveys are used for inpatient, ambulatory surgery, and emergency department services. An outpatient survey for laboratory or other diagnostic testing outpatient services is being implemented.

Typically, access gets high scores on the ambulatory surgery survey. This shows that processes and services are working well in the same-day surgery center, women's surgical center, and general operating room registration areas.

"We are lucky that the hospitalwide patient satisfaction initiatives are supported and monitored at the highest levels of the executive leadership team," says Bowen. "So the data, good and bad, as part of the structured process, are intrinsically shared with senior leaders."

A dedicated director of service excellence assists the department in monitoring and meeting its patient satisfaction goals.

Senior leadership also recognize departments by conducting "rounds" and in-person visits. Good results are recognized by presenting gift baskets to be shared with employees. Official "Certificates of Achievements" are given, and proudly displayed.

"We were recently pleased to have received one of these certificates in recognition of achieving our patient satisfaction percentile goal for the third-quarter of FY 2010," reports Bowen. ■

Want to improve? Don't rely on surveys alone

Relying on patient satisfaction survey scores alone to drive your improvement efforts is probably a mistake, says **Michael F. Sciarabba**, MPH, CHAM, director of patient access services at Advocate Illinois Masonic Medical Center in Chicago.

"Raw scores in the registration domain, on scheduling, registration, privacy and wait times should be used as a critical measure to monitor," says Sciarabba. "But, patient access must find other ways to make improvements. Departments should be proactive and creative to impact the scores successfully."

Here are some strategies used by patient access leaders at Advocate Illinois Masonic Medical Center:

• Registration hands out survey cards.

This keeps survey questions "top of mind" for staff. At the same time, it makes patients aware of the department's goals.

Results are tracked and trended, with the survey card results compared to other satisfaction survey scores. "Distributing the survey cards is especially effective in outpatient registration," says Sciarabba.

The cards use the same questions and rating scales as the hospital's other satisfaction survey. The difference is that with the cards, patients give immediate feedback. "The patient can then 'connect' the process to what they are rating," says Sciarabba.

The department was able to zero in on the response for "waiting time in registration." Ninety percent of patients who received cards immediately at registration rated performance for this measure as "very good." "These registration wait time scores were shared with leaders to communicate how successful patient access was in minimizing wait times specific to registration," says Sciarabba.

However, the survey results did not reflect this positive finding. In comparing the results, many patients were in fact rating their overall wait time. They included, for example, the time they spent waiting in the lobby for a diagnostic test, even after registration was completed.

To address this, a twofold solution was needed. Registration needed to communicate more clearly with the patient, and ancillary areas had to find ways to consistently improve patient wait times.

• A "Code Service" page is used for service recovery.

This communication strategy is used when service

recovery issues are anticipated. This may involve extended wait times, personal issues, equipment failure, operational errors, or patient complaints.

A Code Service is issued by patient access when action or follow-up is requested from one unit to another. Patient access can give a "heads up" to clinicians when patients have special needs of some kind. For instance, a patient may appear very anxious about not knowing what to expect from a diagnostic test.

"If patient access knows this up front, they can send a page to ancillary clinicians indicating the patient's disposition," says Sciarabba. "Once the ancillary department receives this, they can be prepared to take the additional time with the patient to decrease their anxiety from the initial point of contact." The text page might read: "Code Service, Mr. Smith, CT Abdomen & Pelvis, Patient is upset about condition and has many questions."

The Code Service page can alert management that an intervention is needed. "Patients that arrive without required physician orders are a constant challenge for patient access associates," says Sciarabba.

In this case, a Code Service text page can be sent to a manager reading, "Code Service, Mrs. Jones, needs X-ray, no order present and cannot reach physician office, need manager to speak with patient." A manager can then present to the area right away and speak with the patient immediately to provide service recovery.

Lastly, a Code Service page can be sent when patient access needs additional help due to a sudden surge in volume. That message might read, "Code Service, outpatient registration, 10 patients waiting to register for over 10 minutes, need help."

"Sending the Code Service page only takes a minute or two, but it can have a positive impact on the patient experience," says Sciarabba. "It improves communication between departments, ensures an effective handoff, and informs management when intervention is needed."

• Implement regular leadership rounding on employees and patients.

A concierge position was created and integrated into the patient access department. This person rounds in waiting areas and directs patients appropriately.

"Ultimately, patient access must create a number of goals focused on patient satisfaction that personalize service to the patient," says Sciarabba. He says that the two key drivers to success are tracking and trending results consistently and integrating patient satisfaction goals into individual staff performance improvement plans.

"Patient access must be able to tell their story, to show their effort and share their data with department heads and senior leaders," says Sciarabba. "Improving patient satisfaction is difficult, but can be achieved — one patient at a time."

Catherine M. Pallozzi, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital, says the department previously used Press-Ganey surveys to gauge satisfaction, but she found that "it was very difficult to zero in our registration. Quite often after reviewing a concern, it was found that the wait time was not registration, but it was the service department."

When measuring satisfaction, Pallozzi says that the greatest challenge is focusing in on the brief moment the patient is with the patient access staff member.

"Patients do not know, nor should they need to know, that this facet of their visit is patient access, versus this aspect that is another department," says Pallozzi. "The best customer service experience is that when the patient states the experience was excellent from the first encounter with staff to the last."

One way to gauge the overall level of satisfaction is by the number of complaints you receive. "Complaints are always an opportunity to improve your service," Pallozzi says. "When I assumed responsibility of registration, we had a significant number of complaints stemming from wait times. That was what the leadership team focused their efforts on. We now average two service complaints a year."

Use data to make changes

Satisfaction scores and patient comments, whether good or bad, are posted in work areas for access staff to see at Emory University Hospital Midtown in Atlanta. "We review this data with our staff. Collectively, we brainstorm to develop ways to improve satisfaction," says **Elease Brown**, assistant director of patient financial services. "We look at wait times, courtesy — whatever the issue is."

Everyone in the facility has access to these patient satisfaction scores. "We have even shared our action plans for improving scores, or maintaining good ones, with our senior leaders," says Brown.

One of the primary concerns identified by patients involved waits and delays. "We've always monitored our wait times in registration. While they appeared to be good to us, some patients felt they were not," says Brown. "We reviewed and enhanced a few of our processes, particularly those related to urgent admissions."

Staff now ensure that non-scheduled, same-day admissions are pre-registered prior to arrival. "We work with physicians' offices and transferring

facilities to obtain as much information as possible prior to the patient's arrival," says Brown.

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Make a good first impression: It's critical

Improving patient satisfaction is "a high priority" for the patient access department at Advocate Illinois Masonic Medical Center in Chicago, according to **Michael F. Sciarabba**, MPH, CHAM, the hospital's director of patient access services.

"We believe strongly that we have an important role in transforming the patient experience," says Sciarabba. "A positive first impression is critical to that end."

Patient access staff, says Sciarabba, are the ones who "guide our patients through the complex world of health care. As a critical support department, improvements must be continuous to positively impact the patient's impression of the hospital and our department."

In light of this, any process and technology improvements made by patient access must always consider the impact on patient satisfaction. "Still, the ability of patient access departments to meet established organizational survey goals are complex and challenging," says Sciarabba.

Here are some successful approaches to improve satisfaction:

• Create a patient access team.

This was recently implemented at Methodist Charlton Medical Center in Dallas, with the goal of providing timely patient access to health services in all areas of the hospital. The team places specific emphasis on the emergency department.

All members of the patient access team meet every two weeks to act on and review initiatives to improve patient throughput. They also monitor dashboard metrics related to patient throughput across the organization.

"We look forward to working collectively as a team to improve process efficiency and efficacy," says **Jeanette Foulk,** the hospital's director of admitting/discharge.

The patient access team includes the hospital's president, vice president of operations, critical care director, inpatient director, representatives from care management, human resources, the emergency department, the hospitalist medical director, chief nursing officer, admitting/discharge director, ED director, and the cardiology/radiology services director.

Here are the patient access team's goals:

• Quantifiably assess barriers to excellence, and recommend resources to eliminate these.

• Drive systemic accountability toward achieving best-practice benchmarks and processes for ongoing monitoring.

• Provide recognition to individual members for meeting milestones toward metric benchmarks.

• Recommend organizational changes and policies and procedures in support of patient access and flow.

• Implement action steps through teamwork to "hardwire" sustainable change and excellence across the organization.

• Create a culture of organizational change related to improving access to health care services for communities served.

• Use kiosks to survey customers.

Emory University Hospital Midtown in Atlanta recently piloted patient satisfaction kiosks. These allowed the access department to survey patients about particular areas of registration. Two kiosks were placed in corners of the waiting area to allow privacy and avoid a "backup" in the area.

"We used the data to determine if improvement was needed, and to reward staff who were mentioned for doing a great job," says **Elease Brown**, assistant director of patient financial services. "We reviewed these data with our staff. Collectively, we brainstormed to develop ways to improve satisfaction. If our budget allows it in the future, we may pursue it again."

Upon completion of registration, patients were encouraged to go to the kiosk to complete the survey. If time did not permit, the patient was invited to return to complete the survey. Here are some of the registration questions patients were asked:

• Were you pre-admitted (registered via phone) for today's visit? If you spoke with a staff member by phone, how courteous was the person you spoke with?

• Please rate your overall satisfaction with your registration experience today at Emory University Hospital Midtown.

• Please rate the ease of the registration process and waiting time in the registration area?

• What was the degree to which you were informed about delays in the center?

• How well were billing and insurance questions handled?

• Please rate the comfort of the waiting room.
• How helpful was the staff at the registration reception desk?
• How courteous was your registration representative today?

"We tried to capture most aspects of the registration experience," says Brown. "There was an option to enter comments and leave a contact number as well. We chose to have candy kisses as our token of appreciation for completing the survey, because they were less costly due to volumes." Other tokens considered were parking passes and coupons for movie theaters, the hospital cafeteria, and local restaurants.

Weekly summary reports were received. "We reviewed them to see which areas our patients were most satisfied or dissatisfied with," says Brown. "While most of the ratings were high and comments were positive, we did receive some that required our attention."

Surprisingly, patients also gave some unsolicited comments about other areas. "Admissions and physical therapy were the only areas involved in the pilot, but I guess patients needed an avenue to express their concerns about other areas as well," says Brown.

• Give patients tokens of appreciation.

Emory's access department is "constantly looking at ways to improve patient satisfaction," says Brown. One small way of doing this involves "wowing" patients with tokens.

"These are things to let them know who we — admissions — are," says Brown. "Each patient, in all registration areas, is offered an emery board with our logo. They are a big hit, even with the men."

Also, patients are given a personalized, handwritten thank you card when they make a payment. This helps with upfront collections in all areas of admissions, including the emergency department, pre-registration, inpatient, and outpatient departments.

"Our pre-registration staff members will mail the cards, along with the receipt, to patients who make upfront payments via phone," says Brown. "We've received positive comments about the thank you cards."

• Use role playing.

When a new patient access employee is hired at the Cleveland Clinic in Independence, OH, he or she attends an eight-hour customer service training program including a lot of role playing. The new hire interacts with "patients" who are nervous or angry about various situations, says **Susan M. Milheim**, senior director of patient financial services.

Each year, employees attend a four-hour "refresher" course. Training staff act as the patients, using real-life examples provided by front-line staff or customer service representatives. One scenario involves a patient who has come in as a direct admit and is irate because he thinks waiting for a bed is taking much too long.

"Role playing is very important. It gives the employee the opportunity to practice their newly learned skills," says Milheim. "The role playing is videotaped and available for employee review for future reference or a quick refresher." ■

Want your worst problems fixed? Ask staff

Whether your biggest "pain point" is a sudden surge in denied claims, terrible compliance with a new payer requirement, or a slowly growing trend of unhappy patients, the solution comes from the same place. Your staff know the answers — whether they realize it or not.

Start by asking staff for some feedback to improve processes during staff meetings. "This engagement allows everyone to have buy-in and make suggestions based on their experiences during patient interactions," says **Nancy Jamie**, director of patient access at East Orange (NJ) General Hospital. "This input and level of involvement allows managers to identify any drawbacks prior to implementing or revising a process."

It also makes staff feel more involved with the decision-making process. "After we have covered all the agenda items during our monthly meetings, I take the remainder of the meeting for open discussion," says Jamie. During this time, staff are encouraged to speak about anything that is relevant to the department.

One topic of discussion involved patients who were seen by a primary care physician coming back because they misplaced their referrals. "One of our front-end staff recognized that patients were returning for multiple copies of their referrals," says **Lynette Massey**, manager of the family health center. "The staff member then spoke with me, and it was brought up at our staff meeting."

The group discussed some ways to efficiently improve this process. Ultimately, a binder of patient referral copies was created, which could be maintained for six months. "With this process, patients can obtain a copy of their referrals from the patient access department," says Jamie. "This has served multiple purposes."

Patients say that having this information easily

accessible has prevented them from having to reschedule appointments with specialists. For the clinical staff, the process saves the time required to retrieve a patient's medical records and make multiple copies.

"This has proven to be successful, and a time-saver for everyone," says Massey. "We also spoke with our clinical team to make them aware of the new procedures. We asked that they assist with educating our patients."

The patient access department at Albany (NY) Medical Center started a new rounding initiative in order to connect with staff more closely. The leadership team asks these questions: "What is working well?" "Are there any team members that I should recognize?" "Do you have the tools and equipment you need to do your job?" "Is there anything that we, the leadership team, could do better?" "What else would you like me to know?"

"The greatest takeaway is additional recognition of staff," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access. "The manager cannot be everywhere all the time. This provides the opportunity for the manager to recognize staff that they have been told about."

These questions are not meant to replace the informal contact managers already have with staff, such as making personal inquiries about their family, children, or a special event.

"It is done in addition to this. The questions are pointed to the workplace," says Pallozzi. "It provides another opportunity for the manager to reach the staff member at a slightly different level. It opens up a different opportunity for the manager and staff member to form a better relationship."

A yearly survey of patient access staff is conducted each October. "This has proved to be an invaluable tool. We have had much success, with a 79% to 82% return rate, and for surveys that is wonderful," says Pallozzi.

The unit results are reviewed with the manager to discuss any issues that need to be redirected. The overall survey results are reviewed at the December quarterly staff meeting. The managers are expected to review the unit-level survey response at the monthly unit meeting.

"Certainly, the survey has identified some of the day-to-day needs that were easily rectified," says Pallozzi. "Once you commit to a survey, you need to be open-minded to whatever information is provided to you." Here are some changes the department made:

- Automatic doors were obtained for registration, as patients were having great difficulty opening the doors.
- Specific training sessions, which staff wanted to attend, were provided.
- The monthly newsletter was reformatted and shortened to encourage all staff to read it.
- Valet parking hours were increased in the emergency department.
- Staff were provided coverage for all breaks and lunches.
- Hours were increased in a particular unit. "A staff member thought it was worthy of consideration, and it was," says Pallozzi. "These are all small things, with the exception of the doors, but we eventually got them. I always say it is not the big things that matter to staff as much as the small day to day."

However, Pallozzi says that the most significant change came about when staff provided constructive feedback about their manager.

"Issues such as communication and visibility were brought forward. The staff truly provided insight on what they wanted from their manager," says Pallozzi. "The results were reviewed with the manager. Certainly, at first, it stung a bit."

Pallozzi and the manager worked through each of the issues. In turn, the manager explained how she felt about the situation and how she was going to resolve the concerns voiced by her staff.

"I have had this same opportunity with two other managers during my tenure. It was difficult, but the end result is that retention has never been better," says Pallozzi. "The team is truly a functional team with compassion for each other, and with a true investment in the unit goals."

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Brag about your POS collection incentives

Like many improvements in patient access processes, increasing up-front collections is not as easy as it sounds. One way to facilitate this is by giving staff incentives.

Tammy Casados, patient access manager at St. Anthony Central Hospital in Denver, says that one

of the department's accomplishments in 2009 was the implementation of an at-risk incentive program for associates, tied to point-of-service (POS) collections. The department also invested in estimation software, which allows associates to quote pricing to patients. This enables accurate up-front collections.

The program gives incentives to patient access staff to collect money for co-pays/co-insurance, deductibles, and uninsured patient portions. The goal is to offset bad debt and increase net revenue. For emergent patients, collections occur after the medical screening examination has been performed.

The facility has a department goal to reach 100% or more of the target collections, as opposed to individual goals. The financial counseling office, registration, central scheduling, and cashier offices all make a group effort for the incentive.

"We all work as a team to reach our target goal. The team can look daily at our front-end collections, posted by the central business office, and see where our numbers are," says Casados. "They'll push harder to collect so they can receive their monthly bonus."

Target dollar amounts are set for each point of service, including outpatient, emergency department, inpatient, and same-day surgery. "Each morning, we can check our front-end collections to see where our percentage is. Staff can see how many more dollars we need to meet our target for the month."

These guidelines are used for the program:

- Goals are established as per approval from finance and senior leadership teams.
- Payments will be paid to the eligible associates based on facility attainment of targets as previously established.
- The plan pays on POS collections only. POS is defined as collections posted at zero through five days after discharge or registration.
- Daily tracking of associate collections and metrics will be the responsibility of the patient access department.
- Payments will be paid out monthly for each calendar month, on the pay period following the end of the previous month.
- Payments will be based on productive hours worked in the previous month and paid as a percentage of those hours multiplied by the midpoint of the grade for which the associate is based.
- The associate forfeits the total amount of payment award if he or she voluntarily or involuntarily leaves Centura for any reason prior to the payout for that respective month.
- The associate must be in good standing with the organization (no written corrective action) in order to participate in that respective month's plan.
- There is a maximum per person payout of $12,500 annually.
- The minimum payout will be $25.
- Payments will be paid and taxed according to IRS regulations.
- Evaluation of the goals and targets will be done at least twice per fiscal year and may change/delete or modify eligibilities as necessary. If changes are made, advanced communication will be completed prior to implementation.
- Target changes cannot be made at the entity level. Rather, all target changes should be done at the system level with approval from patient access directors and CFOs.

The front-end collection spreadsheet is broken down by point of service categories of outpatient, ED, inpatient, same-day surgery and online payments. "We also check daily if our front-end collection report payments posted to the wrong account," says Casados. "Invalid account numbers can be a pitfall. Correction needs to occur within five days for it to be posted towards our POS."

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Novel approach gets constant improvement

Wait times reduced significantly

Imagine you're a patient calling to make an appointment. You may wait an extended period of time before the call is answered. Or, someone may answer the call and then put you on hold or route you to another person who cannot help you. Either way, you're not getting that appointment as quickly as you could be, and you're likely to be dissatisfied.

The first patient access process, begun in 2004, is the first to be revamped by continuous improvement efforts at the Cleveland Clinic. The initiative has examined every way in which patients get access into the organization.

For outpatient care, "this may be as simple as helping to ensure the phone call you are making connects you with someone who can actually schedule an appointment," says **Darryl E. Greene**, the clinic's executive director of continuous improvement. "This is critical for an individual

concerned about scheduling an appointment and getting the care they need."

First, the percentage of missed calls was measured, by comparing the number of incoming calls to the number that were actually answered. "We saw an opportunity to improve," says Greene.

For example, during a one-month monitoring of calls to a clinical division, the percentage of missed calls during an eight-hour period could be 20%, with 350 calls answered versus 450 incoming calls.

To get frontline staff involved, data on their performance were shared during a six- to eight-month period. This involved manual collection of data in each department on the number of calls that came in between 8 a.m. and 5 p.m. and how many of these were answered. "The percentage gap was shared with frontline caregivers regularly, so they could see how they were performing," says Greene.

By 2005 , there was a target of 5% missed opportunity for most clinical divisions. Since staff knew this was being measured, they were motivated to figure out what they could do to make a difference.

"Additional service-level metrics like abandonment and average speed to answer were gathered clarifying missed calls," says Greene. "The value of this transparency with data led to targets, standard protocols, defining training needs, and team efforts to perform better."

Starting in 2006, the patient's ability to actually get an appointment was evaluated. "Imagine now that a patient got through to somebody, and now wants to schedule clinic time with a physician," says Greene. "We looked at how long it took to get access measured by time to scheduled appointment. How many days wait was there? Could they get in the current week, or did they have to wait an additional third or fourth week? We found out that we had a lot of challenges behind the scenes."

This involved looking at "slots availability," the number of clinical hours available for a given physician each week to provide care. "We try to give the provider the benefit of the doubt as to the reason why their slots aren't completely filled. They might be reserving that time for other priorities — doing research, for example," says Greene. "But we started measuring this, too, and gave real-time data back to physicians for a given area."

The goal was to enlist the help of providers in getting better access for their patients. "We wanted them to see how absolutely critical it is to do all we can to make sure the patient has access to a physician," says Greene. "Coming up with solid metrics, making the information very transparent, and reviewing it with the CEO regularly was incredibly helpful."

Within areas, teams looked at slot utilization, and then tried to determine the reasons why some providers had more slots filled than others. "We looked at the reasons for lack of parity, then tried to work toward parity," says Greene. "But we didn't tell them what we had to do to get slots filled. It was left up to them to work through that."

The Mellen Center in the Neurological Institute looked at how to increase appointment availability for follow-up patients with multiple sclerosis. Physicians, nurse practitioners, medical secretaries, and patient services representatives met and found unequal distribution of slots among clinicians.

There was also under-utilization of certain slot types. Solutions included converted slots, to allow nurse practitioners to see patients individually. This allowed for hundreds of additional slots.

"Slot utilization is a behind-the-scenes metric," says Greene. "What the patient experiences is the number of days the patient had to wait to be seen."

Data were shared on what percentage of new patients could get into an outpatient clinic within seven business days. "We found that 50%, based on historic data, was a good starting point," says Greene. "As the years progressed, we became more sophisticated in our processes and ability to provide transparency. What was manual in 2004 is now electronic."

Electronic dashboards display this percentage as well as gaps in performance to targets. Any provider can check the current statistics on how many days it takes to perform at a 50% level for getting access within seven days. "Some may have 25 days, and they need to ask, 'What's driving us to have this many days wait?'"

In some cases, it's not enough to just provide data, business intelligence, and to review with executive leadership. Providers may need some help with problem solving.

In this case, a multidisciplinary team comes

COMING IN FUTURE MONTHS

- Use claims denials as learning tools
- When to involve security for potential fraud
- Offer incentives for passing CHAM exam
- Effective strategies for chronic complainer

together to review the data and analyze the issue using a collaborative problem-solving method.

"Just looking at data doesn't always give you the answers," says Greene. "If a unit is hitting eight, nine, or ten days before getting to a 50% level relative to a target of seven days, they are able to ask the team to help them look at it."

The team may includes clinicians, nurses, administrators, and coordinators who schedule and collect medical records. One solution a team in the Taussig Cancer Institute came up with was to improve the ability of staff to "triage" the caller's need for care.

"If staff are able to access medical records earlier on in the process, that can help to determine which physician they need to see sooner," says Greene. "So we ask patients to provide them earlier on. This gives us information from the patient upfront that in turn allows us to puts them with the right physician in a shorter time frame than before."

When a call is received by a clinical nurse specialist for a new patient or referring physician, basic information is obtained regarding the diagnosis and testing done to date. The patient is then triaged to the appropriate specialist.

If records are needed to triage the patient, they are faxed and appointment scheduled within one day of receipt. All new patients are scheduled within seven days of the initial phone call for the Cancer Institute, as a result of this process.

Attention is now being turned to a patient's ability to get a same-day appointment. Frontline staff are now asking new patients who call if they would like an appointment that day.

"To provide performance data, we have a metric for 'appointment when wanted,'" says Greene. "Patients are later surveyed, after they have gotten an appointment, with one question: 'How would you rate the ease of getting an appointment when you wanted one?'"

"Same-day access was a big deal in pediatrics, which paved the way. That is now a critical measure for us," says Greene. "We are seeing the value proposition and quickly starting to propagate it. It is a metric now for the Cleveland Clinic."

The goal is to create the most desirable experience for patients from the time that they call for an appointment to the end of their visit. "Creating a process for patients that is seamless and efficient is absolutely paramount," says **Kelly Caine**, patient access coordinator at the Cleveland Clinic's Mellen Center. "One important part of creating that ideal experience is meeting the patient's expectation of timely medical care."

Appointment availability was created in each department reserved for same-day purpose alone. "This creates a fluid process that is void of delays for both the scheduler and patient," says Caine. "Patients are often very surprised that we offer appointments within the same day that their calls are received." ■