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Provide access staff momentum even when salaries remain stagnant

Invest in your front end

It's no secret that the responsibilities and skill level of most "front end" staff have expanded greatly, while financial compensation has typically not kept pace. As a result, "patient access staff will demand higher salaries," predicts **Antionette Anderson**, CHAA, CHAM, director of patient access and centralized scheduling at Skaggs Regional Medical Center in Branson, MO.

"Patient access is now the upfront business office," says Anderson. "They have to be recognized for what they do. We have to invest in patient access staff, just as in the past we did this for the back end."

Anderson says that across the country, recognition of the importance of front-end staff is beginning to grow. "It is very important that the director of patient access fight for this, and the CFO understand exactly what the front end does," she says. "If not, staff will move on to other departments."

Stop staff from moving

To promote staff development within her department, Anderson created a career ladder with five rungs. Each rung increases the employee's hourly wage by 25 cents, she says, except for the fourth, which gives a 40-cents hourly increase, and the fifth, which gives a 50-cents increase and requires passing the Certified Healthcare Access Associate (CHAA) examination, for a maximum total increase of $1.65 per hour.

"The first three rungs can be attained in their first year of employment, the fourth in their second year, and the fifth ring in their third year," says Anderson. "They have to maintain all of the rungs."

A fellow employee has to recommend an employee for the career ladder, explains Anderson, and his or her immediate supervisor must provide written justification.

Anderson notes that the hospital pays for the CHAA examination,

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and provides staff with the right tools such as accuracy software, electronic insurance verification tools, and cost-estimator software. "I think this is very important, as their salaries are stagnant," she says.

Invest in front end

Paige Bohannon, director of admissions at Hendrick Health System in Abilene, TX, says that staff retention has been a challenge in her department. "Our main challenge is keeping the college students that we hire engaged in the job," she says. "They are willing to do the odd shifts for a while, like working weekends and night. But sometimes they lose interest."

Bohannon retains employees by making them feel like they truly belong. "It is harder to leave when you feel like you are a part of a group or a family," she says.

Staff in the various patient access/registration areas have the opportunity to move up the department's career ladders as they master different levels of their job, Bohannon explains. "Also, they have the opportunity to move within the department, to learn different aspects of the department," she says. "Scheduling, insurance verification, patient placement, and admissions are all very different."

Bohannon cross-trains her staff as much as possible, giving them the chance to try out working in the ED and outpatient and diagnostic areas, and working with direct admits and patient placement. She hires temporary "floaters" who are trained in all the different areas.

"Usually, those floaters will take a full-time position when it becomes available," says Bohannon. "It also gives the floaters an opportunity to see all the areas and choose which area they enjoy best."

Bohannon does her best to show her staff that in patient access, "the opportunities are endless." Lead and supervisory positions are offered for the different shifts and areas, she notes.

The hospital's career ladder is based on length of employment, dependability, quality, and productivity, says Bohannon. "Everyone participates. It's not real formal — they don't have to apply to participate," she says.

Several employees have started at the entry-level position and worked their way up to supervisor and even director, reports Bohannon. "One of our current supervisors has worked here for 12 years, all in patient access," she says.

This man began his career as a representative in the trauma center, then went over to the center for rehab, came back to the trauma center as the lead rep, was promoted to trainer, and is now supervisor over trauma admissions and patient placement, says Bohannon.

While positions in patient access don't require a degree, most other positions within the hospital require either a degree or certification, notes Bohannon. "Our positions are not always looked at as a 'career' position. We have to promote that." Here are some changes Bohannon made to improve retention:

- **A "morale committee" was created.**

These individuals organize snack days and pot

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lucks during work, as well as annual picnics and Christmas parties outside of work, says Bohannon.

• Each employee receives a bookmark that lists his or her good qualities, such as "smart," "professional" or "conscientious."

• A "You're a Keeper" card is filled out by patients if they encounter someone who is doing a great job or going above and beyond.

"This is read to staff during quarterly department meetings," Bohannon says.

• Two employees are featured each month in the hospital newsletter.

• The entire staff are bought dinner when quarterly goals are met.

In general, Bohannon says that she makes a point of focusing on an individual employee's strengths. "This ensures they are placed in the appropriate positions," she says.

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Gain 'intense loyalty' from access employees

Always acknowledge good work

If a registrar makes a mistake that results in a needless claims denial, and the following day notices an error that prevents a denial, which is more likely to get your attention? "We often forget to thank people for good work, but we are very quick to criticize them when something goes wrong," says **Michael S. Friedberg**, FACHE, CHAM, associate vice president of patient access services at Apollo Health Street in Bloomfield, NJ, and author of "Staff competency in patient access."

"It is very important to acknowledge an employee when they do a good job," he underscores.

If you do this consistently, according to Friedberg, "some of what you get in return is an intense loyalty. And that is a really valuable asset to have."

Friedberg says that this kind of loyalty "is absolutely a retention tool. We've all experienced a vice president of revenue cycle going to a new place and bringing all their people in."

You'll get some amount of respect just from your title, says Friedberg, but "to really be a respected boss, you have to earn respect from the members of your team. Loyalty is a two-way street, and it has to be in both directions."

Recognition motivates

The main motivator for patient access staff is not money, Friedberg says, but recognition. "Throwing money at a problem, increasing salaries will work, but it is a short-term solution," he says. "In health care, in particular, money is very hard to come by, especially these days. You have to figure out ways to motivate your people without giving them more money."

Friedberg says he is hearing from his colleagues around the country that there is reduced turnover in patient access due to the economy. He recommends "getting out in front of that. Make sure that you recognize talented employees. Give them opportunities for growth." Here are Friedberg's suggestions to make employees feel valued at work:

• Identify individuals with potential.

"It's always been important to me to identify and recognize people who may be in entry-level jobs — and in access, there are a lot of them — who have potential for growth," says Friedberg.

The next step, he says, is to figure out how to tap into that person's potential. "Employees who make $30,000 or $35,000 a year can double or even more than double their compensation, if they work in a place that will allow them to grow," says Friedberg.

As a manager, says Friedberg, you need to give the employee what he or she needs to get to that next level. For instance, Friedberg recently gave a junior staff member books to read about management and leadership, and is working with her to develop her own leadership style.

You will always have some people who are comfortable in an entry-level position and don't want to become a manager, says Friedberg. "You need people like that as well. In fact, that is the group that runs your department on a day-to-day basis," he says. "But there are people in your department who are not only capable of more, but want more."

These individuals may not always come out and say it, though, says Friedberg. "You have to recognize people's skill sets, and what they have the potential to be good at," he says.

• Own up to your own mistakes.

"It's important to talk to these folks about mistakes that you've made, and how you've overcome them," says Friedberg.

• Help employees to move up.

If your organization has a management training program, Friedberg says to encourage key staff members to pursue it. "I think that putting somebody into one of those programs and having them succeed is a huge feather in your cap," he says. "It is a compliment to you, that you were able to recognize the talent."

If an employee is able to maintain the highest level on the department's career ladder, says Friedberg, it's an excellent retention tool that usually means some extra compensation.

"Many of the patient access departments that are 'best in breed' have a career ladder and training opportunities as part of their program," he notes.

• Invest in training.

Staff may be promoted because they are good at the job, says Friedberg, not necessarily because they have good management skills.

"One of the things that we do not do very well at all in health care is train people," says Friedberg. "When somebody goes from registrar to supervisor in the same organization, that is the hardest transition to make. The rest of the staff feel, 'Yesterday you were my colleague, and today you are my boss.'"

• Give credit to staff.

"When it's time for credit, always take a back seat and tell everyone it was the team," says Friedberg. "Acknowledge those people who helped you accomplish a goal."

• Tell staff to volunteer.

Years ago, Friedberg attended a seminar where the speaker spoke about being the "go to" guy or gal, and he gives that advice to his staff to this day. "I tell them, if somebody wants you to take notes at a meeting or do grunt work of some kind, that's how opportunities find you," he says. "If you view it as a job, it's a job. But if you view it as a career, you will get a different result."

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Surge in underinsured, self-pay? Use these tips

The utilization of services by self-pay patients has increased by 6.9% over the last fiscal year at St. Joseph's Hospital and Candler Hospital, both located in Savannah, GA, says **Susan M. Younggreen**, director of patient financial services.

As a result, Younggreen says that patient access staff have recently become more proactive about informing patients on how they can receive help with their bills.

Registrars refer patients to the hospital's financial counselors and/or the Medicaid eligibility vendor, inform them of prompt-pay and self-pay discounts, and provide financial assistance applications with instructions, says Younggreen.

"This is really not a new role for the patient registrars," says Younggreen. "They are just providing more information than before, and are doing so without being asked."

Collections were decreasing

Access staff have done point-of-service collections for inpatients, same-day-surgery, imaging, and ED patients for about four years, says Younggreen, but over the past two years, collections have been slowly decreasing.

"We are currently in the process of implementing an initiative to increase collections," she reports. "We have identified the most successful collectors, and are having them coach the others."

The coaches do some role-playing, says Younggreen, which gets less experienced staff more comfortable with collecting from patients. "We are emphasizing that customer service and respect for the patient is more important than collections," she adds. "This was just initiated at the beginning of the year. We have no results yet, but we are optimistic."

While the hospital's financial counselors are a part of patient accounts, these individuals work closely with the registrars, notes Younggreen. In November 2010, the hospital revised its financial assistance process, which included a 65% self-pay discount for uninsured patients, she adds.

"We increased the visibility of our financial assistance program on our website, as well," says Younggreen.

Patient satisfaction is always a priority, says Younggreen, so staff members attempt to address

any concerns the patient has about his or her bill as soon as possible in the patient experience. "This may be at pre-registration time, or the day of the visit," she says.

The coaches offer refresher sessions to the registrars, says Younggreen, which review the different methods of financial assistance. "We provided scripting for the registrars to use when offering the financial assistance application," she adds. "The scripting was designed to put the patient at ease. We offer assistance in a way that is not embarrassing."

Major changes made

The hospital's financial assistance program was already "fairly liberal," according to Younggreen. "We use a sliding-fee scale. Anyone applying who makes 250% or less of the poverty guidelines qualifies for a 100% write-off of their balance, even including the deductibles and copayments after insurance," she reports.

A person making up to 500% of the poverty guidelines could qualify for a percentage discount ranging from 15% to 90% of the balance, adds Younggreen, depending upon income and the size of the bill.

The sliding-fee scale also changed, so the least amount of discount a patient without insurance now receives is 65%, says Younggreen. "In November 2010, our charity write-offs were 21% over budget, but we were still running 4% less than last year," she reports. "The full impact of the change has yet to be determined."

New access roles

"We have seen a steady increase in self-pay/underinsured patients in the past two years," reports **Lee Anna Mull**, patient access manager at Mission Hospitals in Asheville, NC. Managers recently created a financial counselor position to focus solely on the inpatient "self-pay" patient, due to greater volumes of these patients.

"Currently, we have someone on site that gets a report each day on the self-pay patients," says Mull. Staff screen these patients to see if they have insurance that was possibly not entered into the system, explains Mull, or if a patient might be eligible for vocational rehabilitation or Medicaid.

"If the patient is a true self-pay, a financial counselor will visit the patient's room and complete a charity care application," says Mull.

In the emergency department, financial counselors meet with self-pay and underinsured patients at the time of their visit, adds Mull. "They meet with any patient who needs financial assistance or has an outstanding balance," she says. "We are hoping to reduce the amount of uncollected dollars in A/R."

Many options to offer

"We have many options for self-pay patients expecting a large balance," says Mull. "We are able to offer the patient a prompt-pay discount. We can assist them with an affordable, interest-free monthly payment plan."

The patient can apply for a charity care discount based on federal poverty guidelines, household size, and income. Staff offer a catastrophic discount for balances of $10,000 or greater, if the patient is incurring large hospital bills.

"Financial counselors actively pursue collection efforts on bad debt accounts that have been placed with a collection agency," says Mull. "Accounts are placed with an agency, if all attempts to work with the patient have been exhausted."

These steps are taken before an account goes to collection, says Mull:

1. The patient receives a series of monthly billing statements requesting payment in full.

"Those with insurance do not get a statement until after their insurance has paid," Mull notes.

2. Patients receive a past-due statement if they do not respond.

A collection representative may place a call to the patient and offer a payment arrangement or a discount for payment in full, says Mull. "They also take financial assistance applications for charity care consideration over the phone with the patient," she says.

3. Patients receive a final notice statement prior to their account being placed with a collection agency.

"Ample time is given for the patient to settle their account balance before moving it to an agency," says Mull.

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Asking for money? Enlist help of best staff

Two employees excelled both at cash collection and customer service at William Beaumont Hospital in Royal Oak, MI, says **Cheryl L. Webster**, director of patient registration services. Webster asked them to train her front-end staff.

"They pulled information from their own experiences, as well as other written training tools we have provided to staff on the topic," Webster says. "When they needed something developed, they worked with their supervisor to organize the materials."

The two individuals presented these materials to small groups of their colleagues, says Webster, and answered questions, shared tips, and offered their support. "We are expanding this approach in our refresher training in 2011, due to staff feedback," says Webster.

The staff trainers compiled a list of common patient objections and some responses that worked for them in the past, says Webster. "They focused on body language, compassion, and service," she adds. "Our focus is to be firm, but kind, when asking a patient for payment."

Webster says that staff should maintain "confident but not judgmental" body language. "We never want our patients to feel that the money is more important than their care," she says. "We work very hard to balance our service and revenue cycle responsibilities in every encounter with our patients."

The staff trainers offered these tips to their coworkers:

- When asking for payment, do not ever ask if patients want to make a payment. Assume they will be paying by asking, "How will you make your payment today? We accept Visa, MasterCard, Discover, personal checks, or cash."
- If a patient indicates that he or she cannot pay the entire amount of a prior balance due, say, "We really need to have you make some sort of payment toward the balance. How much can you pay today?"
- If patients indicate they cannot make any sort of payment, give them a financial counselor's phone number for follow up. "If the patient is uninsured, we have a packet of information on Medicaid and various assistance offices," says Webster.

"In 2010 we improved our overall cash collection by 25% using our updated training tools and processes," says Webster.

To help staff with collections, the department added a link to its billing system so that the patient's current balance is visible. "Not all balances are included," notes Webster. "We are working to add a little more detail to help staff answer questions."

When the questions get too detailed for staff to handle, they refer the patient to the hospital's billing office. "We try to balance the time our staff take in this process and not let it create back logs," says Webster.

Every day, supervisors receive a report on patients with outstanding balances, adds Webster, so they can audit that the staff requested and collected payments and noted the accounts.

"When they find that a staff member did not request payment because the account is not noted, they follow up with an education session to give our staff more help," says Webster.

Staff are given a list of patients coming in for a scheduled service in the future, says Webster. "We can flag the visits for a discussion regarding payment when the patient arrives, if they did not pay during the pre-registration phone call," she explains.

Supervisors celebrate successes every month, says Webster, by posting the team's cash collection as well as that of the "star" who collected the most.

At times, patients will give feedback about a staff member who did not request payment in a compassionate manner, she notes. "When that happens, we work to help him or her request payment using a more positive, friendly approach," says Webster. "We monitor closely, so our staff do not cross over to a more aggressive method."

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Observe staff: Are skills top-notch or lacking?

Since **Pam Kast's** office is part of the main admitting area in her hospital, she sees and hears her staff in action on a daily basis.

"I counsel staff on inappropriate patient

encounters, and compliment pleasant ones," says Kast, manager of patient services for the admitting office and emergency department areas at Botsford Hospital in Farmington Hills, MI.

One patient was upset because she wrongly assumed an appointment would be at the hospital, when the physician's office had scheduled it at an off-site location, recalls Kast.

First, the registrar called the physician's office to see about relocating the test to the hospital. She then worked with the hospital's scheduling office, the testing department, and finally the insurance verification area to get the test scheduled and authorized.

"My registrar saved the patient a trip to an unknown location and the [frustration]of misunderstanding about the appointment," says Kast. "For this, I awarded her with Botsford bucks."

These come in $1, $2, $3, and $5 denominations, which staff use for purchases at the hospital's cafeteria, gift shop, and coffee shop, she says.

Kast rewards her employees for successful cash collection efforts in the ED, pitching in without complaint to help a coworker, getting things done or stepping in to help if a patient requires more help.

"This is often related to cash collection," she says. For example, if a patient is taken aback that a $25 copay is owed, sometimes just having someone else step in is enough to help the patient understand the requirement, she says.

"Even when I'm not around, my staff let me know when there's been a good assist," says Kast. For instance, staff may tell her, "Suzy Q helped get that collection," she says, or "Mr. Smith took out his wallet after she explained his coverage."

On another occasion, Kast heard a registrar say, after realizing that a patient failed to bring the physician's order for a test, "I will have to call the doctor to get his order." "My registrar's inflection caused the patient to apologize," says Kast. "Although she acknowledged, "'It happens; don't worry,' I knew she could have better handled the exchange."

Once the patient was on her way, Kast pulled the registrar aside to review the situation. "I asked how it could have been handled so the patient would not have felt the need to apologize," she says. "I suggested that the registrar could have said instead, 'Let me call the doctor's office to get a copy sent over,' or 'I'll just call the office for you, to get a copy of it.'"

Kast notes that since becoming a Level II trauma center in 2010, many patients are arriving in very critical condition. While clinical staff are well trained on the care to provide, says Kast, patient services staff also are encountering this new patient population.

"They are being presented with a much higher anxiety level by the loved ones of these patients," says Kast. "To assist them, Botsford Hospital's security officers have had training that helps them to calm highly anxious family and friends of trauma patients."

Through the patient's eyes

Kast is often offered helpful input from various areas of the hospital. "The best part is feedback from hours when I'm off work," she says. "The upper management team helps by rounding and reporting good and bad behaviors to the appropriate department manager."

Kast got one comment on a staff member helping a patient across the parking lot in a wheelchair to get her prescription filled at the outpatient pharmacy.

Kast says that her current focus is the ED entrance, which is the "front door" for walk-in patients. "I'm partnering with the security director, since his department and mine share the walk-in entrance," she says. "We hold joint meetings, ensuring that staff from both departments hear the same message about customer service expectations."

Kast tries to look at the hospital's ED through the eyes of patients and their family members. "I ask myself, because my people have a small area and patients don't like to see a mess, is the area clear of unnecessary stuff?" she says. "Does it appear that my people are all engaged in work activities?"

Watch and learn

Patient access supervisors at St. Joseph Medical Center-Towson (MD), occasionally call their own staff to see how they answer the phone, says **Mary Crawford-Perry**, manager of registration. "We make sure the call is answered in three rings. If not, then we call back to talk to them about why they didn't answer the phone," she says.

When Crawford-Perry wants to know if things are working smoothly, she uses a concept from the hospital's "lean team," which works on process improvement hospitalwide, called "20 minutes in the box."

"It is amazing what you will learn when you take the time to just watch a process," says Crawford-Perry. "This is especially true when it comes to customer service. It is kind of like secret shopping."

When a patient comes in for surgery, the front desk alerts registrars electronically, says Crawford-

Perry. "Then registration knows that the patient is waiting to be registered, so the patient feels like we are expecting them," she explains.

Registrars greet the patient and introduce themselves by name, says Crawford-Perry, and in areas with offices, they go out to escort the patient in.

"We have self-check-in for registration, and sometimes patients need help," says Crawford-Perry. "We want to make sure that the patient isn't standing there, struggling with the system. There is someone right there to help them."

Crawford-Perry's biggest pet peeve is when someone doesn't introduce him- or herself by name when talking on the phone to a patient. "I call in on the weekends to see how staff answer the phone," she says. "The first thing I will tell them is, 'Please make sure you identify yourself,' if they haven't done so already."

Crawford-Perry expects staff to escort patients to a volunteer who will bring them to their destination. "We remodeled our front entrance. Some of the locations are a long walk, especially for some patients with severe health issues," she explains. "We also have greeters that will take patients if the volunteers are not available."

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Data show how staff measure against peers

Before a patient access employee starts work at Bronson Methodist Hospital in Kalamazoo, MI, he or she takes a proficiency exam, says **Patti Burchett**, director of registration and central scheduling. "That is the first level of us being able to assess whether they 'get it' or not, before they even hit the door."

Verification and authorization weren't something that access staff had to concern themselves with a few years ago, notes Burchett, but those processes have moved to the front end. "Accuracy when the patient is still here is absolutely critical now," she says. "Those skills have been added into our training."

Burchett says that data on accuracy, collections, denials, and patient calls are her primary tool to assess the skills of staff. "We are very heavy on measurements. We do a lot of monthly reporting," she says. For the first time, the department is using individual-level blind data, which allow employees to see how they measure up against their colleagues.

"The other tool we use is a gainshare program, which is based on the hot topic of the year," says Burchett. "If we want to focus on point-of-service collection, we will set targets for the year. Every quarter, the department has an option of receiving a benefit if those targets are reached."

While bar graphs showing individual staff members' performance are currently blinded, next year Burchett expects that the employee's name will be revealed. "If you are the low man on the totem pole and you are stopping the department from receiving the bonus that quarter, they're going to know that," she says.

Goal: 100% compliance

Burchett does random audits for areas such as verification. The department is currently aiming for 100% compliance with employees giving the notice of privacy to patients, she says.

"We will go through 30 employees on a weekly basis so we have a benchmark," she says. "It's more real-time than waiting for the end of the month, or worse, the end of the quarter."

Burchett also does some direct observation to assess customer service of her staff. "We don't do secret shopping, but process management is out there. At times, staff aren't aware that they are being observed," she says. "Thankfully, I've never been in a situation where somebody treated someone poorly."

Burchett continually looks for ways to improve processes, in order to reduce wait times. "It may be that if there is only one printer that staff keep running to, that you need another printer. If you spent the money and had four printers, it could decrease wait time by two minutes," she says. "Employees might be happier as well."

Calls monitored

Managers routinely monitor calls to see if staff are obtaining all of the required information from the patient, says Burchett. "The managers absolutely love that tool, and not only from the perspective of customer service," she says. "If you get a denial and you can prove that, 'On the call, we discussed X, Y, Z,' that lost paperwork all of a sudden reappears."

Managers look for recurring errors on the calls, says Burchett, as an indication that staff need some remedial education. "It may be a specific requirement for a payer, such as needing an authorization within 24 hours," she says. "The industry changes so quickly in terms of those kinds of requirements."

While authorizations were always needed for Medicaid patients, commercial insurers typically required these only for high-dollar services. "Now, it's a brand new world out there," says Burchett. "You have to get verifications and authorizations for every kind of procedure that you can think of. The time that it takes to obtain those is increasing."

To help with this, says Burchett, a new data accuracy system is being implemented. "It's so important that the claim drops cleanly," she says. "Hopefully, we will see claims go out more quickly and payments come back more quickly."

The hospital's patient and family advisor council is another source of valuable input for Burchett's team. "They bring their perspective on whatever we are trying to work on, including a number of patient access initiatives," she says. "This is done primarily in the form of Kaizen events, which are a Lean process improvement tool."

The team makes the final decision on what the process should be, says Burchett, and then it is tested and re-evaluated. "The council members have assisted in work on our ED triage process, verification process, and notice of privacy process," she reports. "They have also worked on developing content for patient brochures that discuss wait times, physician information, and billing expectations."

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Turn reluctant staff into first-rate POS collectors

More complex role

Holly Hiryak, MNSc, RN, CHAM, director of hospital admissions/access services at the University Hospital of Arkansas in Little Rock, says that while financial counseling is not a new role for her access staff members, the role has become considerably more complex.

"In our facility, we are centralizing this role for our inpatient, ancillary, and outpatient services," she says. "We are in the process of finalizing the role and expectations."

The department is seeing more self-pay patients who do not qualify for any kind of assistance, reports Hiryak, and are able to pay something toward their care. "We are also aggressively collecting at the point of service for all areas. This has been a real shift, especially for our ancillary areas."

As for salaries, Hiryak says, "Unfortunately, we have hit a plateau for access here. The [salary of] the new financial counselor role is actually higher, which I am pleased with."

Patti Rhode, director of patient access at Affinity Medical Group in Menasha, WI, says that a process to estimate patient responsibility is used only when significant expenses are likely, as with orthopedics, surgery, and obstetrics. "We have a staff person that will guesstimate the charges to the best of their ability," says Rhode. That individual contacts the patient's insurance companies for pre-authorizations and determines what they will cover to calculate what the patient's out-of-pocket expenses will be, she says.

"They remind the patient that this is only an estimate," says Rhode. "Situations can change, which would impact the procedure, surgery, or delivery. That would, in turn, affect the final charges."

Rhode says that many insurance companies have discontinued printing copayment amounts on insurance cards, making it more difficult for staff to collect. "In some cases, we can get that information through our eligibility software," she says. "However, not all companies are contracted with them."

Much of the time, Rhode says, staff have to rely on the patient to provide the correct information. "Not all patients are receptive to paying at the time of the visit. They want us to bill them," adds Rhode. "Also, some registrars are uncomfortable asking for the copay, especially if it is not clearly indicated on the card."

More difficult role

At Children's National Medical Center in Washington, DC, patient access staff have always been expected to collect, and this has been tracked for years, says **Carole Helmandollar**, executive director of ambulatory services.

"This is not a new role. But it has certainly become more difficult in recent years, with high-

deductible health plans that many of our families just don't understand," she says.

Helmandollar has set up some internal competitions between ED staff and the inpatient patient access staff to promote collection activity. However, she says that "our message for staff is not to ever become confrontational, or too insistent, with the families. If staff get any pushback, they should drop it and refer the families to our financial information center staff."

Eligibility vendors staff those positions, says Helmandollar, and they are much more experienced at having conversations about finances. "While they don't actually collect from the families, they are skilled at the negotiations around this," she says. "They have been tremendously resourceful in developing a positive outcome for many of our families."

If a child has been admitted to the pediatric intensive care unit, says Helmandollar, parents sometimes become incensed that staff are asking for their copays.

"The only difficulty we have is managing the patient expectation very early in the process. This, unfortunately, sometimes causes customer service issues," says Helmandollar. "While this occurred in the adult facility where I worked previously, it seems heightened in the pediatric setting."

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Reap these benefits with online payment option

They expect this option

Your patients probably expect that they'll be able to pay their hospital bills online, just as they do with all their other bills. "More and more, people are paying all their bills online," says **Kathy Peterson**, director of patient financial services at CVPH Medical Center in Plattsburgh, NY. "They don't have to write a check, don't have to get a stamp, and can wait till the final due date to pay. It is instantaneous."

Patients at CVPH have been asking for the ability to pay their hospital bills on line for quite some time, says Peterson.

When an online billing process was implemented, the hospital's marketing department did a large media blitz. "The local television station came and interviewed me, and had it on the evening and morning news for a day or two. It was in the newspaper as well," says Peterson.

Flyers were inserted in the billing statements for several weeks as well, to let patients know they could pay online, says Peterson. "We have a message right on the statement, as well as on our phone system when patients are on hold," she says. "Patients can also view their statements online with this tool, thereby saving paper for the statement we didn't have to mail."

Fewer incoming calls

Previously, patient accounting staff took a large number of phone calls each day from patients who wished to pay their bills via credit or debit card, says Peterson.

Patient accounting staff have been impacted the most by the new process, says Peterson, as they have significantly fewer phone calls to take each day. Also, she explains, they do not have to post these payments, because they post electronically.

With fewer incoming phone calls, staff are freed up to make more outgoing calls to collect on outstanding bills, she notes. "Patient access staff haven't been affected just yet, but they will be in the future," says Peterson. "We plan to roll out the ability to take copays at all access points via credit cards/debit cards, using the online bill pay system."

This way, says Peterson, staff will know immediately if the card is accepted or rejected and they can e-mail a receipt to the patient.

Patients are happier

Patients still have to call in to make payment arrangements or if they have questions about their bill, says Peterson, but otherwise they no longer have to make a phone call to make their payment. Patients are very happy about this, says Peterson.

"They can make the payment at their convenience," she says. "As a result, we have fewer phone calls we have to take from patients wanting

to make payments over the phone."

Many patients also mailed their payments in with credit card information, and are now paying online, says Peterson. "So we no longer have that volume of mail to open for payments," she says. "The payments post via 835 electronic remittance, so nobody has to actually key the payment into the system."

In the first month of going live at CVPH, more than 600 patients paid their bill online, reports Peterson.

"This just screams that our patients want more technology and convenience at their fingertips," she says. "We are seeing all kinds of payments come through the web, large and small."

Peterson says that she expects this number to grow. Looking forward, the department has started the process of having an online registration screen, she says, where patients can pre-register for scheduled procedures/tests online.

"The success of the online bill payment tells us clearly that patients want the convenience of doing things at the time they want to, and in the comfort of their own home," says Peterson.

The department is looking into the possibility of allowing patients to have real-time online chats with customer service staff. For example, if patients look at their statement and they have a question, says Peterson, rather than calling in and waiting in a queue, they can request a real-time chat with a customer service rep.

"We are looking at how we can provide convenience to our patients, which will thereby improve satisfaction as well," says Peterson. "We will also be exploring online appointment scheduling."

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Cleaner registrations from 'front-door' consolidation

All scheduling and registration functions now report to the access management team at Methodist LeBonheur Healthcare in Memphis, TN, as a result of consolidation of front door functions, says **Jessica Murphy**, CPAM, corporate director for patient access services. This has reduced fragmented reporting structures, she says.

"We have learned that in a health care setting that is large and multi-faceted, all scheduling and registration functions need to report to the access management team to ensure quality and adherence to policy and procedures," says Murphy.

This means a more seamless process for patients who might be seen in any one of the facilities, says Murphy, and provides accountability for consistency of services.

One of the best examples, says Murphy, is the department's approach to scheduling outpatient testing or therapy, outpatient surgery, and planned admissions. Previously, the ancillary service areas at each of the six hospitals decided individually how physician offices would access them to schedule their patients.

"That literally meant a string of phone numbers for provider offices to post by the phone, in order to know how to schedule any requested services from Methodist Le Bonheur," says Murphy.

Murphy's access team worked with the administrative teams at each facility to centralize all scheduling calls into one department.

"In all but one of our hospitals, that department reports to patient access," says Murphy. "Eventually, we hope to have one scheduling division across all hospitals, providing 'one-stop shopping' for our providers to schedule patients for services."

"Scheduling is a critical partner to registration/admissions," says Murphy. By joining those functions into patient access and having a single reporting structure, she says, there has been a significant improvement in the quality of registrations. Here are some examples:

- Registrations are more accurate, because a thorough search is now made for the patient's existing medical record number.
- Scheduling errors were reduced, such as scheduling inpatient-only procedures as an outpatient status.
- Out-of-network patients are redirected to in-network facilities for non-emergent services.

COMING IN FUTURE MONTHS

- Go the extra mile to keep patients happy in waiting areas
- New education role on horizon for access staff
- Revamp your processes for patient identification
- Learn some potential pitfalls with registration kiosks

• Spelling errors have been reduced.

"Scheduling staff have a newfound understanding of the information they gather, and its importance to the registration process," says Murphy. "This allows them to be a vital part of protecting the financial front door."

The pre-certification specialist nurses from utilization management were moved to patient access services for all outpatient services. "They have become part of the team that consolidates and drives front-door activity for our patients and our providers," says Murphy.

Schedulers and registrars turn to these nurses to get questions answered quickly and easily, says Murphy.

"Their clinical expertise helps the schedulers and registration associates with questions, ranging from medical terminology to payer contractual financial requirements," she says. "We have experienced significant improvement in adherence to access policies and procedures."

All of these areas now work together as a team with a single mission, says Murphy — to get a clean registration that gets the claim paid efficiently.

"In my role, I can participate in and affect decisions and process designs for any of these areas, not just admission- or registration-related functions," says Murphy.

The "finger-pointing blame game" does not work well within a structure of single, direct reporting, adds Murphy. "Instead, it becomes a matter of the team itself working to improve processes, or re-structure education, when there is a bump in the road," she says.

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