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AHC Media

Patient access world is changing: Prepare for new service challenges

Warning: Your staff must be `very skilled'

(Editor's Note: This is a special issue of Hospital Access Management *that is focused on patient access and customer service. Inside, we give strategies for handling the most challenging customer service situations, including using feedback from patients to improve their satisfaction, giving patient access staff members the ability to provide excellent service, and evaluating the customer service provided by members of your department.)*

"I've already been asked for that information 100 times. Why are you asking me again?" This commonly heard question is one example of patient frustration being directed at registrars through no fault of their own.

"The patient access world is changing, in terms of trying to collect co-pays, increasing ED utilization, security issues, fraud, and complex family situations," says **Patti Burchett**, director of registration and central scheduling at Bronson Methodist Hospital in Kalamazoo, MI. "There are an increasing number of questions, authorizations, and verification requirements that patient access specialists must consider during the process."

All of these factors make satisfying patients harder than ever for registrars, says Burchett. "Staff has to be very skilled in how to manage those situations," she says.

Registrars are one of the first "faces" seen by patients and their

EXECUTIVE SUMMARY

Patient access staff members often encounter challenging customer service situations, and patient satisfaction has become a top priority for many departments. To achieve results:

- Make changes based on patient comments in surveys.
- Use a standard process for all complaints, even if unfounded.
- Set goals on the departmental level to encourage teamwork.

families when they come to the hospital, says **Lynn Craven**, patient access director at St. John Providence Health System in Warren, MI. Craven confirms that staff members smile as they greet patients and family members and say, "Hello. How may I help you?"

A few registrars have been recognized by Craven as "service excellence associates." "Their purpose is to help others within the department to develop and hone skills to improve interaction with our customers," she says.

Here are some strategies for particularly difficult customer service scenarios:

• Obtaining accurate registration information from an emergency department patient.

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**

Editorial Questions
For questions or comments, call Joy Dickinson at (229) 551-9195.

Patient access staff members are committed to obtaining complete insurance and demographic information before patients leave the facility, even in the emergency department, says Burchett.

"They work with the physicians and clinical staff to ensure the patient is promptly seen and treated, while balancing the need to capture demographic and financial data prior to discharge or admission," she says.

As part of Bronson's commitment to patient and family-centered care, initial registration is completed at entry and asks for name and date of birth. The full registration is completed in the patient's room, where the patient has more privacy and is better able to provide details once symptoms are addressed.

Previously, staff used stationary computers with their backs to the patient, says Burchett. "The computer laptops are now on carts, so staff are always face-to-face with patients," she says. "This improves patient and staff satisfaction, since it is more personal and safe."

• Having to ask for information the patient already has provided.

Staff now use scripting to explain why the same question is asked multiple times, says Burchett. "We stress that it's in the patient's best interest," she says. However, the department is also looking for ways to reduce the number of times patients are asked for information.

Bronson is installing software based on the concept of "one patient, one record," says Burchett. For example, if a patient presents to a primary care physician practice, his or her information will flow over to the hospital and all of the ancillary departments, she explains.

"If it is a current registration, staff shouldn't have to be asking for that duplicative information any longer," she says. "We expect that to be a huge satisfier."

• Explaining to patients why others were seen before them.

Some patients come to the outpatient testing area for scheduled tests, while others are unscheduled, which can cause dissatisfaction, says Burchett.

"We are looking at better ways to route those two different types of patients," she says. "Right now, they all come into the queue the same way."

An unscheduled patient might have 10 people ahead of her, says Burchett, and that patient sees a scheduled patient taken right in.

"It looks like that person got to cut in line

ahead of them," she says. "We are trying to address that from a flow perspective and a customer perception perspective." One possibility is to have separate areas for scheduled and unscheduled patients with good signage, says Burchett.

• Explaining benefits when patients don't understand their coverage.

"For various reasons, such as language barriers or age, many patients do not understand what their insurance policies cover," says Craven. "This creates a need for us to educate the patient and family, at a time when they may already be under stress."

Staff members make an extra effort to explain the various payment plans offered. "This allows families to determine the option that will best work for their situation," says Craven. "Financial assistance and other social programs are also offered when necessary."

• Registering a patient who arrived without all the necessary information.

To prevent this, a pre-registration process was implemented in Erie, PA-based Saint Vincent Health Center's outpatient area. "Prior to a patient presenting to the hospital, we will pre-register them if they have been a patient here in the past 60 days with the information we have," says **Rose DiLuzio**, patient access manager.

Registrars obtain necessary authorizations or referrals before the patient comes in the next day. Once the patient arrives, registrars verify their demographic and insurance information, copy the patient's insurance cards and driver's license, and ask them to sign any required forms.

"We then put the armband on the patient, hand them their orders and labels, and direct them to the appropriate outpatient area," says DiLuzio. "All of this is done in about three minutes." *(See related stories on utilizing patient input, above right, improving customer service, p. 76, and evaluating the service provided by your department, p. 76.)*

SOURCES

For more information on providing excellent customer service in patient access areas, contact:

Patti Burchett, Director, Registration and Central Scheduling, Bronson Methodist Hospital, Kalamazoo, MI. Phone: (269) 341-6370. Fax: (269)341.6648. E-mail: burchetp@bronsonhg.org.
Lynn Craven, Patient Access Director, St. John Providence Health System, Warren, MI. Phone: (248) 849-3429. E-mail: Lynn.Craven@stjohn.org.
Rose DiLuzio, Patient Access Manager, St. Vincent Health Center, Erie, PA. Phone: (814) 452-5006. E-mail: Rdiluzio@svhs.org. ■

Listen closely to what patients are telling you

Don't miss valuable information

If a patient takes the time to complain about your patient access department or to give a compliment, listen closely.

While Press-Ganey surveys track scores for helpfulness, ease of the registration process, and wait times on a monthly basis, personal remarks can be the most helpful, says **Patti Burchett**, director of registration and central scheduling at Bronson Methodist Hospital in Kalamazoo, MI.

"The great thing about the survey is that we also get comments back. It is not just a score," she says. "Many times, the comments are much more valuable than just a raw number."

One patient commented on the use of pagers, which are given to patients by greeters in outpatient registration areas when it's time for them to go back for their test. These aren't available on weekends due to lower patient volume, and a frustrated patient reported having to wait longer as a result, says Burchett.

"We are looking into how that can be added on the weekend, so patients will have less time standing in line," she says.

Occasionally, a patient gives a compliment without identifying an employee by name. "We can trace that back, using dates of services, to identify when the comment came through and who was working that day," says Burchett. "It may take some digging, but we can figure out who the staff person was."

Burchett says she makes this effort because "we take customer service very seriously here. This is a very high-level strategic initiative for us. We want our staff to know that they will be recognized when they go above and beyond."

Use standard process

If a patient complains about the way a call was handled, or claims that misinformation was given, the department manager listens to the call to see what actually was said, says Burchett. Regardless of whether the patient is correct, Burchett says her staff members follow the "Three As," of Acknowledge, Apologize, and Amend.

If a patient complained about a long wait time, for example, a registrar might say, "I can see

you've had a long wait. I apologize for your inconvenience. What can I do to best help you now?"

"We have a standard process to handle complaints, whether they are founded or not," says Burchett. Employees also listen to the phone call and answer the question, "How can we do this better next time?"

Connie Campbell, director of patient access of Mercy Medical Center in Oshkosh, WI, places pads of paper in registration areas stating, "Your voice is important to us," with postage-paid envelopes attached. "We receive both compliments and complaints," says Campbell. "People say what is on their mind, which is the whole aim."

Each month, Campbell sends the comments directly to department managers, such as a recent comment from a family member who wanted to be more updated on estimated wait times for patients in surgery. "I then write up the action plan they gave. It goes out to the CEO and our whole management team, so they know what patients are stating about the 'front doors' and their experience with us," she says.

Comments can be as simple as someone writing, "This was a very pleasant experience," says Campbell. "Once, they stated, 'Your hallways are so long. Can you add in some park benches? So we did," she says. ■

Up your odds of giving top customer service

Learn from members of your staff

Patient access staff at Methodist Hospital in Kalamazoo, MI, are assessed for customer service as part of the criteria for the hospital's bonus program, says **Patti Burchett**, director of registration and central scheduling.

"Good service is the right thing to do for the patient, but there is also a monetary incentive as well," Burchett says. "That is a big part of how we hold them accountable."

Customer service is evaluated on Press-Ganey scores, with targets established using the previous year's data for the organization's quarterly gainshare bonus. Goals are at the department level, not the individual level, so everyone must work together as a team to achieve results, notes Burchett. "The department establishes three goals, with one being focused on customer service," says Burchett. "If the target is achieved, staff would be eligible for a third of the bonus as it relates to Press-Ganey."

Monthly reports on survey data applicable to the registration staff, along with patient comments, are reviewed for process improvement opportunities, says Burchett.

Managers round on the floors with a focus on customer service and visit every registration area at least once a month. "When they round, they are not observing. They are asking for input from the staff, to obtain ideas from them," Burchett says. Simple questions such as "How is your day going? or "How is the patient environment today?" can give valuable insight, she says. Staff may tell the manager, "We had two call-ins, and we are sinking. I need help!" "My computer isn't working," or "The department has more people on the schedule than we anticipated."

Whatever staff report, managers are sure to follow up the next time they come back to the area, says Burchett. "They will say, 'Thank you for bringing this to our attention. Here is what we did about it,'" she says. ■

Learn whether service is first-rate, or far from it

Your patient access staff are responsible for the patient's very first impression of the hospital. "If something does not go right in the patient access area when the patient arrives, then it sets the tone for any other department treating that patient," says **Rose DiLuzio**, patient access manager over ER registration, outpatient, and admitting at St. Vincent Health Center in Erie, PA.

To assess the service provided by staff, use these approaches:

• **Measure wait times.**

At Bronson Methodist Hospital in Kalamazoo, MI, department managers constantly measure the number of calls coming in and how long before each call is answered.

"We don't want people to wait," says **Patti Burchett**, director of registration and central scheduling. "In outpatient testing areas, managers track how long it took for patients to get registered and then to get back for their test, or door-to-floor."

If something is inhibiting customer service, Burchett says staff members are encouraged to make changes themselves. "We call that a 'just do it,'" she says. "The people who do the work know more than anyone what needs to happen to make

an improvement." In the ED, registration forms might not be organized in a logical manner, she explains, or a scanner or printer might need to be moved.

• **Observe staff.**

Lynn Craven, patient access director at St. John Providence Health System in Warren, MI, says that face-to-face observation gives her the chance to provide feedback and acknowledge an associate while "in the moment." "This serves as a motivational tool for continued growth," Craven says.

Bronson Methodist's process improvement department does observations for patient access areas occasionally, says Burchett. "They observe wait times and process. Sometimes staff know they are watching, and sometimes they don't," she says.

DiLuzio observes staff by sitting in an adjacent registration booth and listening to the conversation taken place. "We try not to let the patient access associate know we are monitoring this," she says.

Patient access staff members are observed almost daily in the emergency room (ER) and less frequently in the admitting and outpatient areas. "I have a team leader in the ER that is a hands-on individual," says DiLuzio. "He is constantly monitoring staff for productivity and any types of patient concerns that arise."

• **Use secret shoppers.**

Craven says that in her department, hospital associates as well as managers' own family members have been used as secret shoppers.

On occasion, "secret shoppers" have been used in the ER at St. Vincent to help evaluate an associate with a pattern of inappropriate behavior. "This is not a problem we experience frequently," says DiLuzio. "My staff knows that I do not tolerate behavior that will make a patient uncomfortable or not want to come back to our facility."

• **Record phone calls.**

This recording allows managers to assess how the registration staff is interacting with customers, says Burchett.

"Right now, if a customer has a concern, we review the recorded phone conversation. There may be an opportunity to coach the individual or to clarify an item for the team," she says. ■

Multiple providers seen? Collect multiple co-pays

When patient access leaders at Cincinnati (OH) Children's Hospital Medical Center took a close look at multidisciplinary clinics, it was determined that many of them were collecting a single co-pay even when patients saw multiple providers, says **Michelle Gray**, MHA, director of patient access and outpatient registration.

"When speaking of co-pays, the multidisciplinary clinics were an area that was overlooked. Now, it is the focus of our attention," says Gray.

Some clinics collected co-pays only for the host department and not for the other providers, says Gray, but they, too, were billing the patient. One reason for this being overlooked was that some of the hospital's multidisciplinary clinics were incorrectly classified, says Gray.

"We generated a spreadsheet to determine how many multidisciplinary clinics we have here at Cincinnati Children's," she says. "We are still adding clinics to that spreadsheet."

Pushback from providers

Patients are accustomed to paying a single co-pay for the entire visit, explains Gray, but if they see multiple providers, then multiple co-pays are due. A patient with a $20 co-pay would owe $80 if he or she saw four providers in the clinic.

Patient access staff now inform patients that by coming to a multidisciplinary clinic, several providers are in one location for their convenience, says Gray. There's no need for patients to go to separate clinics, she explains, but they still need to pay co-pays for each provider they see. "We're working with the business directors to generate a letter to patients, notifying them in advance that they may have multiple co-pays," says Gray. "This has been a slow process, and we are having to deal with provider push back."

Some providers don't want their patients to pay multiple co-pays for a single visit, she says. "It is a payer requirement," Gray says. "Our senior level executives are telling us they want it collected on the front end. There is a cost associated with sending that co-pay bill."

EXECUTIVE SUMMARY

If a patient sees more than one provider at a multidisciplinary clinic, multiple co-pays might be required. To improve collection:

- Explain to patients that several providers are in one location for their convenience.
- Notify patients in advance that multiple co-pays might be required.
- Share the co-pay collection process with all involved departments.

Word has gotten out

Gray has met with the business directors of the host departments to share the new process with them.

"Word has gotten out about the need to collect co-pays," she says. "They know it's coming down from our senior leadership, and they want to cooperate."

There is ongoing discussion about the best way to collect multiple co-pays, says Gray. In some cases, patients don't know which providers they will be seeing during their visit. For example, the vascular malformation clinic includes providers from ear, nose, and throat; hematology; pediatric surgery; and dermatology, but patients don't always see all of these providers. "We collect after the visit, when the clinic knows which providers have seen the patient," says Gray.

One of the biggest challenges is to simply get the patients to stop by the registration desk on their way out. "Sometimes, they just leave," says Gray. "This process requires a collaboration of team members to ensure this co-pay collection on the back end works." *(See story below, on making registrars accountable for co-pay collection.)*

SOURCE

For more information on co-pay collection, contact:

• **Michelle C. Gray**, MHA, Director, Patient Access/Outpatient Registration, Cincinnati (OH) Children's Hospital Medical Center. Phone: (513) 636-1414. Fax: (513) 636-7531. E-mail: michelle.gray@cchmc.org. ■

Are co-pay collections part of staff evaluation?

Make registrars accountable

Registrars at Cincinnati (OH) Children's Hospital Medical Center now have an added incentive to obtain co-pays: It could determine the amount of their pay increase.

Michelle C. Gray, MHA, director of patient access and outpatient registration, says that in her area, co-pay collection is a metric on each registrar's scorecard, which gives an additional incentive to ask for the co-pay.

"If they have a lot of uncollected co-pays, they will end up scoring low on that metric," says Gray. "Ultimately, it will end up affecting their merit increase."

If registrars are not held accountable, says Gray, there is really no incentive to ask for co-pays. "It is somewhat of a sore point for our registrars," she says. "They don't like being held accountable when a parent refuses to pay his or her co-pay. They feel they are unfairly penalized."

When registrars made this argument, Gray asked them, "So how do I know you are actively asking for co-pays?" "They didn't have an answer," she says. "If we don't monitor this, there is no incentive for them to ask."

Gray also uses the data to identify problems with particular registrars or clinics. "We don't expect registrars to collect 100% of eligible co-pays, but in order to be successful, you must have some accountability," she says. "They need a goal to strive for." ■

Complex authorizations offer expensive mistakes

While some authorizations are straightforward, others can be complex and result in claims denials, according to **Alicia Alampi**, manager of patient access at St. Joseph's Hospital in Syracuse, NY.

"We have seen an increase in the number of authorizations needing pre-certification," she reports.

Elective radiological procedures now require authorizations, says Alampi. "Patients who previously had Medicare and straight Medicaid who are moving to HMO plans, and patients being converted to inpatient status after their scheduled procedures, cause an increase in the number of authorizations we need to obtain," she says.

More and more, insurance companies are asking for ICD-9 codes, adds Alampi. "We are not able to provide these at the time of notification, but the staff does have a narrative diagnosis," she says. Physician offices might fail to notify insurance companies prior to procedures, and payer web sites aren't always up to date, she adds.

Time-consuming process

Central DuPage Hospital in Winfield, IL, is experiencing a 10% growth in its diagnostic imaging service line, and many of these procedures require preauthorization, says **Debbie Milke-Wurster**, RHIT, revenue cycle manager.

EXECUTIVE SUMMARY

Patient access departments are seeing increasing requirements for authorizations, even for services that previously didn't require these. To be sure they're obtained:

- Send weekly updates to staff on insurance updates.
- Facilitate communication between the authorization area, clinical areas, the central business office, and the ordering physician.
- Be sure the authorization matches the service type and the specific test and procedure.

"Processes are always an issue," says Milke-Wurster, giving the example of how the need for pre-certification appears on work lists. "If something is coded wrong or put in a wrong category, it might not be flagged without a manual review. From a clinical standpoint, an additional view or slight modification could be required."

The insurance company might deny the claim if this information wasn't provided before service, says Milke-Wurster. "Additionally, our payer mix is now representing more PPO and HMO product lines, which require pre-authorization," she says. While Medicare and Medicaid currently do not require pre-authorization, PPOs and HMOs are moving more toward online electronic verification, says Milke-Wurster. "This is good, as it gives a written trail and takes less time to complete the task," she says.

A challenging process

The number of insurance plans and the variety of methods to obtain the pre-authorization, whether electronic, phone, or contacting the patient's physician, make this process very challenging, says Milke-Wurster. "In addition, clinical information is often needed, which can slow down the process," she says. "While more insurance companies are offering online solutions, there are still a significant number of times when a phone call is required. Not all insurance companies provide an online solution."

Communication with the physician offices is essential, says Milke-Wurster, as there is required information from both sides. Staff members use a variety of tools, such as a list generated from the system that is more efficient than a manual paper trail, to ensure the pre-authorization is obtained. "This list can be shared amongst users and is real time," she says. "Management can monitor this at regular intervals."

To avoid denials due to new payer requirements, Alampi says that "communication is the key strategy."

Patient access managers inform the verification staff of all updates and changes as soon as these are received from the managed care and patient accounting departments, says Alampi. "We also have an 'Access Communiqué' that is sent out weekly, with all insurance updates to the multiple access points in our network," she says.

Alampi created internal department work queues that allow staff to write the rules for the verification staff. "We also use web sites and an eligibility system, including reports that have been created as a back up," she says. "We want to ensure that nothing falls through the cracks." *(See related story on authorizations related to clinical information, below.)*

SOURCES

For more information on processes for obtaining authorizations, contact;

- **Alicia Alampi**, Manager of Patient Access, St. Joseph's Hospital, Syracuse, NY. Phone: (315) 448-5384. E-mail: Alicia.Alampi@sjh-syr.org.
- **Debbie Milke-Wurster**, RHIT, Revenue Cycle Manager, Central DuPage Hospital, Winfield, IL. Phone: (630) 933-3038. E-mail: debbie_milke-wurster@cdh.org.
- **Carol Plato Nicosia**, CHFP, CPAM, MBA, Administrative Director, Corporate Business Services, Martin Memorial Health Systems, Stuart, FL. Phone: (772) 223-5945, ext. 5656. Fax: (772) 223-5622. E-mail: cplatonicosia@mmhs-fla.org. ■

Missing clinical info can mean no authorization

Martin Memorial Health Systems in Stuart, FL, reports an increase in authorization requirements for inpatient and outpatient accounts.

Authorizations can be time-consuming when they must be obtained and verified via telephone, says **Carol Plato Nicosia**, CHFP, CPAM, MBA, administrative director of corporate business services. "The physician is required to start the authorization process, in most cases," says Nicosia. "Even if the physician obtains an authorization number, hospitals are required to verify the number is correct and, in some cases, activate it."

For this reason, excellent communication between the authorization area, the clinical areas, the central business office, and the ordering physician becomes critically important, she says. Here are some specific challenges:

• Obtaining authorizations for exactly what outpatient test or procedure is being done.

"This sounds easier than it is," Nicosia says. "In many straightforward cases, it may be a simple match, but many cases get complicated. These complications may require re-work after the service is complete."

An authorization might be obtained for a colonoscopy, she explains, but if polyps are removed during the procedure, the billing CPT code will not match a straightforward colonoscopy, which results in a claim denial. "Therefore, if it is likely that polyps will be removed, the authorization should be obtained accordingly," says Nicosia. If the correct authorization is not obtained prior to the procedure, a second call to the payer is required to explain that the procedure changed and needs to be updated in their system, she adds.

• Obtaining authorizations for complex diagnostic services, including cardiac procedures and radiologic interventional procedures.

"These cases have physicians involved during the procedure, and changes may be made to the original order during the actual procedure," says Nicosia. If they do, the authorization would not match and would need to be updated in order to prevent a denial, she adds.

• Getting the authorization to match the service type.

At the time of admission, there often isn't enough clinical information to determine whether an inpatient or observation authorization will be needed, Nicosia says. "Continuous follow-up is required in these cases," she says. "Getting the service type correct the first time helps to prevent denials after claims are sent." ■

With POS collectors, pave the way for `stars'

After patient access staff at UNC Health Care in Chapel Hill, NC, began receiving bi-weekly reports on how much they collected, their performance began to improve.

"We were surprised that when we began publishing the bi-weekly dashboards, those who were struggling didn't struggle any longer," says **Jeness J. Campbell,** administrative director with the Office of Revenue Cycle Management.

Campbell identifies her top collectors with a biweekly staff dashboard that is produced in conjunction with the pay period. "The dashboard shows the total dollars each staff member has collected," she explains.

Campbell sends this data to staff on a biweekly via e-mail and posts it in the work area. She also divides the overall dollar amount collected per staff member by the total number of visits checked in, to calculate the average dollars collected per visit checked-in. "This statistic allows us to most accurately compare across all of our staff, to more easily identify our consistent top collectors," says Campbell.

The data allows her to open the lines of communication with staff members, whether their performance was stellar or sub-par. If it's stellar, she asks whether they did anything differently and why they think they got better results. "If it's sub-par, there may be something going on that we need to know about," says Campbell. "There may be barriers that management can help remove to improve their performance."

Intermittent incentive programs are held, with the top three collectors awarded for total collections as well as average collection per visit. "The awards include differing increments of gift cards to the gas station or restaurant of their choice," says Campbell. Incentive program results are published in weekly team e-mails, adds Campbell, and leaders send personalized thank-you cards to top collectors.

Incorporate incentives

"We find that our top collectors consistently use a tone and words that work," says Campbell. "Therefore, we use those words as the standard for all staff. Top collectors may assist by demonstrating for their co-workers."

Campbell says the phrasing that has proven most successful is "UNC requires an estimated deposit of [$] for today's service. How would you like to pay today?"

"Our goal is to have the top collectors do real-time, shoulder-to-shoulder mentoring," she says.

EXECUTIVE SUMMARY

Encourage consistent collection by accurately comparing staff, offering incentive programs, and sending personalized thank-you notes. Other approaches:

- Calculate the total dollar amount collected and the average dollars collected per visit.
- Include collection in employee evaluations.
- Use unpleasant responses in role-playing exercises.

"Currently, we are just monitoring the top collectors, noting the ways and words that seem to work better than others."

Amanda Gilmore, patient access supervisor at Legacy Emanuel Hospital in Portland, OR, says co-pays "are an automatic part of our registration process." Members of the patient access staff collect co-pays for outpatient diagnostics, pediatric surgery, adult surgery, and the emergency department. They set goals for co-pay collections in each of these areas, based on the volume and expected revenue generation per visit/procedure/surgery, says Gilmore.

Co-pay collection is included as a performance requirement on the department's monthly and quarterly employee evaluation, she says, and a monthly status report lists all departments with a breakdown of amounts collected. "We have incorporated incentives for the collection of co-pays with drawings, gift cards, and recognition for the highest collectors," she says.

ID missed opportunities

Each area has its own "missed opportunities" for co-pay collection, says Gilmore. "Many patients are not completely informed about their insurance co-pays for multiple services," she says. For example, most patients in the outpatient diagnostic department aren't aware of co-pays for procedures such as electroencephalogram, EKG, and ultrasound.

If a complete authorization was not obtained for a surgical procedure, there might be an undocumented deductible or co-pay requirement in the account for the patient access team to reference upon registration, Gilmore says.

Pre-registration, pre-authorization, and pre-verification teams work to obtain the necessary demographic information, insurance authorizations, and verification of amount due, she says. "This supports the patient access department's collection at the time of registration," says Gilmore. "They also serve as a capture point when speaking to the patients prior to arrival." *(See related stories on giving staff the tools to succeed, at right, and patient reactions to new collection processes, p. 82.)*

SOURCES/RESOURCE

For more information on improving point-of-service collection, contact:

• **Jeness J. Campbell**, MBA, Administrative Director, Office of Revenue Cycle Management, UNC Health Care, Chapel Hill, NC. Phone: (919) 966-7029. Fax: (919) 966-1167. E-mail: jj_campbell@unchealthcare.org.

• **Margaret Trudel**, Middlesex Hospital, Middletown, CT. Phone: (860) 358-6864. E-mail: Margaret_Trudel@midhosp.org.

• **"The Revenue Cycle: Big Picture"** and **"POS Collections: Skills for Success"** are part of the *RC360* training curriculum and the *Revenue Cycle Certification Program*. Fore more information, contact The Academy of Healthcare Revenue, Milwaukee, WI. Phone: (888) 700-5223. E-mail: email@academyrcm.com. Web: www.academyrcm.com. ■

Give new collectors the tools to succeed

Remember: It's a new role

A certain group of experienced access representatives were chosen to participate in an emergency department (ED) copay collection pilot at Middlesex Hospital in Middletown, CT, reports **Margaret Trudel**, patient access manager. This team was successful in substantially increasing copay collections in the ED.

"We have since involved other less experienced staff in the pilot, and you can see the difference," she says. "The rate of collection was not as good as it was with the experienced team. That tells me we have to work more with them one-on-one, to get them used to have that kind of conversation."

Trudel is giving staff some additional tools to get them comfortable asking for money, including an online training program and scripting for phone calls. *(See resource on this page for more information on the program.)* Here are some of her approaches:

• Access representatives give a consistent message.

"The script needs to be the same wherever the patient is seen," Trudel says. "We need to push the same message, so we don't get someone from our Shoreline ED saying, 'I wasn't asked for it at the Middlesex ED,'" she says.

Trudel has overheard some of her staff asking for co-pays tentatively. "As soon as they get any resistance, they back off and offer to bill the patient," she says. Access representatives now use key phrases such as "for your convenience" and "you won't have to worry about anything else when you arrive or at discharge," says Trudel.

• Make it part of the access representatives' evaluation.

Staff are evaluated for copay collection and financial assistance as part of their performance

review, says Trudel. When copay collection became part of their role, all access reps were moved into a higher labor grade with a salary increase in most cases, says Trudel. However, this change came with new expectations, she emphasizes.

"The message was delivered that we have confidence in you, and your role is vital to the success of the copay collection process," says Trudel. "We gave them the new job description and the new performance review, and outlined our expectations."

Co-pay collection is now a significant part of the yearly review and interim discussions with front-line supervisors, says Trudel. "You always have your champions who have no problem with it," she says. "Then you have other staff you need to work with to increase their confidence."

Every month, Trudel informs her staff of the percentage and dollar amount of copays collected. "If we have a banner weekend, we share the result first thing Monday morning. That keeps staff motivated," says Trudel. "We haven't gone down the incentive road yet, because we do feel this is a part of their job."

• Give staff the ability to offer help.

"Our self-pay patients are identified upfront," says Trudel. Staff members offer financial assistance during registration and give the application to the patients before discharge, rather than waiting for financial counselors to send out an application at a later date, she says.

There is no dedicated financial counselor in the ED, says Trudel, so access reps are playing that role. "We are educating our staff so they can discuss this with patients with more confidence and give more information prior to the patient leaving," she says.

• Do regular role playing.

Trudel says that when co-pay collection role playing is done, resistant access reps are initially standoffish. "But if you practice on a regular basis, they become more comfortable with it. My plan is to incorporate it into every staff meeting," she says.

If staff are resistant to collecting co-pays, Trudel asks them what happened when they asked for the co-pay. "Usually, their reluctance for not wanting to solicit a copay is because they have had a bad experience," she says. Those are the exact situation that are used in role playing, says Trudel. "If they get some positive responses, and practice dealing with the not-so-pleasant responses, it gives them the confidence they need to pursue co-pays," she says. "I believe it's all in the delivery." ■

Gauge patient reactions to POS co-pay process

When a new emergency department (ED) bedside co-pay collection process was implemented at Middlesex Hospital in Middletown, CT, access reps were "very, very nervous about what the reaction was going to be," recalls **Margaret Trudel**, patient access manager.

Access representatives were pleasantly surprised when many patients told them they liked the new process and found it easier, she says.

After the co-pay was solicited, the access representative then asked the ED patient how they felt about the new process. "It was presented in a positive light," says Trudel. "We were kind of selling it to them by involving them in the process."

Staff told ED patients, "We are piloting a new program, and we are interested in your feedback. Statistics show patients find this to be more convenient, because it saves them an additional stop on the way out and affords them more privacy when paying their co-pay." Patients then were asked to rate the process. "The majority of responses were positive," says Trudel. "Out of 298 patients surveyed, only one response was negative."

Still, Trudel is keeping a close eye on Press-Ganey patient satisfaction survey results, in the event some of the ED patients were not being forthright. "Usually, if patients are unhappy, they will comment on the bottom of the survey," she says. "The assumption is that if we are going to hear that patients were offended by being asked for money at the bedside, we will hear about that on the surveys."

The encouraging survey data on satisfaction was a factor in the decision to roll out the bedside co-pay collection to the rest of the main ED, says Trudel.

Avoid mixed messages

When access representatives at Middlesex ask patients for their co-pay on the day of a scheduled procedure, they aren't sure how to respond if the patient replies, "The nurse told me not to bring anything and leave my valuables at home."

To avoid this kind of confusion, access reps make every effort to collect the copay before the patient arrives. "We really want to get the payment while on the phone during the verification process prior to them arriving," says Trudel.

She is working with the nurse manager in surgical services to be clear about what patients need to bring with them on the day of the procedure. "Their goal is different than ours," says Trudel, adding that the nurse is usually the last hospital employee to speak to the patient prior to the date of their procedure. "While we don't expect them to discuss money matters with the patient, we do want them to remind the patient to bring their license, insurance cards, and co-pay if applicable," she says.

Some nurses are more willing to do this than others, says Trudel. "We have already had the conversation with the patient," she says. "The nurse is not really discussing finances. He or she is just reinforcing the message." ■

Registrars partner with departments on denials

Avoid costly mismatches

Claims denials often occurred because the patient's disposition didn't match up with what the Centers for Medicare & Medicaid Services (CMS) required to authorize a procedure, reports **Maura Corvino**, MSOL, RN, CEN, assistant vice president for emergency services and patient access at Valley Health System in Ridgewood, NJ.

"The physician knew what he wanted to do, but he wasn't writing it in the language that was required for the correct type of admission," she says. These changes were made:

• Patient access staff gave community physician offices a list of the information needed for scheduled patients.

"The office manager provides us with what we need to schedule and speak to the patient, and move forward with the process," says Susan Sigler, supervisor of Valley Health System's patient access center. "We set it up in a way that we think flows nicely for the patient."

• A physician champion visited provider offices to go through an online learning module with physicians.

"This made the communication easier, and the buy-in by the physicians a bit better and faster," says Corvino.

Physicians were instructed to use the CMS inpatient list to validate their intent, says Corvino. "We then verify that what they want equals what CMS allows for that procedure," she says.

The physicians were asked to provide certain data points when requesting an admission or a procedure, explains Corvino. "This facilitates patient access staff in obtaining the necessary certifications and authorizations prior to case day or admission," she says.

• When patients undergo surgery, every step in the process is now time-stamped on an electronic dashboard.

This change means that office staff can keep track of where the physician is at all times, says Sigler. "Previously they were always trying to track their physician down. Were they in the OR, the PACU [post-anesthesia care unit], or in a patient room? So this turned out to be an unexpected benefit for them," she says. "It is a nice perk that has helped engage them in using the system."

This change also means that all of the areas involved in the patient's care can see what is happening, says Sigler. Transport can see when they need to move patients, PACU can see the planned departure time from the OR, and the inpatient units can see when the patient is scheduled to leave the PACU, she explains. "Everybody has that transparency to know what is coming, without needing to scratch their head and wonder when the patients are coming to them," says Sigler. "It allows for the pre-planning of staff and work activities."

EXECUTIVE SUMMARY

Claims denials may occur when a patient's disposition doesn't match the Centers for Medicare & Medicaid Services (CMS) requirements. To avoid denials:

- Give physician offices a list of the required information.
- Have a physician educate other physicians.
- Instruct physicians to use the CMS inpatient list to validate their intent.

COMING IN FUTURE MONTHS

- Proven strategies to cope with surge in uninsured inpatients
- Reduce crowding by revamping scheduling of admitted patients
- Survey ancillary departments to obtain valuable feedback
- Don't give incorrect estimates for out-of-pocket responsibility

SOURCES

For more information on working with other departments on claims denials, contact:

• **Maura Corvino**, MSOL, RN, CEN, Valley Health System, Ridgewood, NJ. Phone: (201) 447-8301. Fax: (201) 251-3467. E-mail: mcorvin@valleyhealth.com.

• **Susan Sigler**, Valley Health System, Ridgewood, NJ. Phone: (201) 447-8000 Ext. 2778. Fax: (201) 251-3467. E-mail: ssigler@valleyhealth.com. ■

Suspect a dishonest patient? Take steps

If a patient gives untruthful information to registrars to avoid paying for services, this fraud can result in dangerous clinical outcomes as well as lost revenue.

Patient access leaders at University of Colorado Hospital in Denver have devoted a great amount of time to identity theft and identity fraud, says **Bob Potter**, RN, manager of access and preadmissions. A multi-disciplinary task force included compliance, admissions, health information management, ambulatory services, emergency department, and patient representatives. "As a result, a policy was developed that was compliant with the anticipated Red Flag Rules," says Potter.

Staff were educated on the following items in the policy:

• identification of perpetrators, using age discrepancies, medical history, signatures, mismatches in registration system, or registration under a different name from previous hospitalization;

• use of an online reporting system;

• registration of a known perpetrators or victims for future admissions;

• close collaboration between campus security and local police.

"This education has resulted in four apprehensions by the police for known perpetrators of identity theft or fraud," says Potter.

Special attention is paid to collecting accurate identity and financial information when evaluating a patient for the Colorado Indigent Care Program or charity programs, adds Potter. "In general, staff has been accepting of our policy. We have brought it down to the level of how it would affect them if they were the victims of identity theft," he says. Staff have noticed cases of a duplicate social security number or an obvious age discrepancy. "They then notify me, and I begin the investigation," says Potter. ■