Hospital Access Management™

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AHC Media

With revamped processes, collect millions in retroactive payments

Patient accounts are 'never a lost cause'

Would you consider one-year-old uncollected account with a large outstanding balance to be a lost cause that ultimately will need to be written off?

"Don't be so sure," says **Nikki Mahieu,** manager of registration services at Trinity Regional Health System in Rock Island, IL.

While retroactive coverage is typically in effect for 90 days prior to the date of service, Mahieu notes that there are certain exceptions for disabled patients. "We will go back to when they were originally diagnosed with a certain illness," she says. "We have had a lot of success with retroactive disability payments with dates of service up to a year ago."

Previously, a vendor reviewed patient accounts with outstanding balances at Trinity Regional and attempted to submit updated information so patients could obtain coverage if they were eligible for assistance. "We found that it wasn't as successful as we thought it was," says Mahieu. "The previous vendor was not very diligent in following up with patients."

In contrast, members of the access staff take extra time to visit the patient while he or she is still in the hospital and show compassion for

EXECUTIVE SUMMARY

In many cases, patient access departments can obtain retroactive coverage for patients with accounts that appear uncollectible. Trinity Regional Health System converted $400,000 in account balances to disability coverage that originally had gone to charity, and the system identified about $2 million in gross charges for self-pay accounts that might be eligible for coverage.

- Have members of access staff follow up with patients while they are still in the hospital.
- Hire a Medicaid specialist to focus solely on disability patients.
- Keep in contact if patients return or their health or financial status changes.

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the patient's overall situation, not just their lack of insurance coverage or unfavorable financial situation, Mahieu explains.

To obtain better results, the patient access department hired a Medicaid specialist who focuses only on disability patients, with 300 accounts reviewed to date. "It has been very surprising. We have been able to convert a lot of patients which we thought were a lost cause," says Mahieu.

Unfortunately, some patients give up when they hit a roadblock in the application processor when they fall just below the criteria for disability coverage, says Mahieu. "We try to keep in contact with patients when they return, or if their health or financial status changes, so we can continue to work their case," she explains.

The Medicaid specialist moves applications through the system faster than access staff would be able to, because she knows exactly what documentation is needed. "Instead of having to wait for one approval and then submitting another, she bundles it all together and sends it on," says Mahieu.

Charity still available

A couple of patient accounts dating back to 2006 are being appealed for disability coverage, adds Mahieu.

"We are hopeful to get these patients on active disability," she says. "Sometimes it is a long shot, but never a lost cause."

Over a six-month period, Mahieu was able to convert $400,000 in account balances to disability coverage that originally had gone to charity. In these cases, the patient came back for a return visit, and patient access staff took the opportunity to review their previous account balances. "We found they had been seen previously for the same issue. So we were able to retroact their disability coverage for dates in 2009 and 2010," says Mahieu.

This disability coverage means that the hospital's charity resources can be saved for patients who do not qualify for any funding source whatsoever, she notes.

Just recently, patient access staff have started looking at self-pay accounts with small balances, which can sometimes be overlooked, says Mahieu. "We have identified approximately $2 million in gross charges that may be potential candidates for Medicaid and disability," she says.

About 6% of self-pay patients seen at Vanderbilt University Hospital in Nashville are approved for Supplemental Security Income (SSI) or disability, says **Marsha Kedigh**, RN, MSM, director of admitting/emergency department registration/discharge station/insurance management, for which the hospital receives retroactive reimbursement. Of the last 62 cases approved for SSI, the hospital received $733,925.32 in revenue, she reports.

9.5% return on retro reimbursement

Currently, the hospital is obtaining a 9.5% return on retroactive reimbursement for the gross charges of these patients.

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"Financial counselors follow every self-pay admission," says Kedigh. "While Medicaid approval will reimburse back to the date the patient applied, SSI reimbursement starts the first of the month after approval."

Stacy Calvaruso, assistant vice president of patient management at Ochsner Health System in New Orleans, says there has been a noticeable increase in self-pay patients, primarily entering through the ED.

"We identified a need to identify these patients as early as possible and to proactively communicate with them regarding their financial obligations," Calvaruso says.

The department implemented a full pre-service center, a no-interest patient loan program, and a propensity-to-pay program. "We have focused on enhanced communication efforts with patients about their prior balances, in conjunction with that day's obligation," adds Calvaruso.

In addition, the hospital contracted with an outside Medicaid eligibility vendor who meets with patients in the major entry areas such as the ED. "We found that we were able to locate many patients who actually had Medicaid coverage," says Calvaruso. "They just failed to contact us and share that information."

Patients typically won't provide this information for a single visit, if they think that they will not return for future services, explains Calvaruso.

"We also took all of our Medicare patients with no secondary payers and ran eligibility checks on them," she says.

About 14% of those patients already had Medicaid coverage, with an additional 16% eligible for Medicaid or a charity care program. "We do attempt to obtain retroactive coverage and have seen positive results," says Calvaruso. "In this past six months, our program has qualified over 700 individuals for Medicaid coverage." *(See related story on self-pay patients, at right.)*

SOURCES

For more information on obtaining retroactive coverage for patients, contact:

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Half of self-pay patients found Medicaid-eligible

At Vanderbilt, counselors assist each one

About half of the self-pay patients presenting for services at Vanderbilt University Hospital in Nashville ultimately obtain Medicaid coverage, reports **Marsha Kedigh**, RN, MSM, director of admitting/emergency department registration/discharge station/insurance management.

"Financial counselors follow every self-pay admission," says Kedigh, adding that 8.2% of the hospital's total discharges are self-pay. "Their process is to verify if the patient truly is self-pay or has coverage."

The counselors assist self-pay patients with submitting applications for Medicaid, Supplemental Security Income (SSI), or disability coverage, which are approved, denied, pending, or non-compliant, meaning the patient didn't apply or didn't follow through with the application process. "This is a long process," says Kedigh.

Members of the patient access staff at University of Iowa Hospitals and Clinics in Iowa City are seeing many more patients with coinsurances without maximums, and larger co-pays and deductibles, reports **Sherri Pitkin**, associate director of patient access management. "From the previous average of $2,500, it is more common to see $6,500," she reports.

Staff members are seeing many more patients with COBRA coverage, adds Pitkin, and the hospital often pays premiums for patients that qualify financially for assistance. The only reason the hospital hasn't seen a large growth in self-pay patients is because many individuals are now covered by IowaCare, a limited healthcare program for adults who normally would not be covered by traditional Medicaid, according to Pitkin.

Although the department does ensure that Medicaid covers all appropriate past visits, this happens usually if SSI or Social Security Disability Insurance coverage also is involved. "We are very efficient at finding traditional Medicaid and IowaCare coverage before services are rendered," says Pitkin. This determination occurs shortly after medical triage unless it's an emergency situation, says Pitkin, and it happens while admitted patients still are in the hospital.

"Our financial counselors and our [Health Care Benefits Assistance Program] social workers assist in filling out Medicaid applications for approximately 85% of our patients that are initially self-pay," says Pitkin. ■

Designate `go to' person for registrars, clinicians

Stop communication breakdowns

In a quick-moving, high-volume area such as the emergency department (ED) of Botsford Hospital in Farmington Hills, MI, communication breakdowns are bound to happen between patient access and clinical staff.

"A common issue is clinical staff not knowing if or when patient access staff has come to register a new ambulance arrival," says **Adam Boyer**, the hospital's information services coordinator for patient services, who helps oversee the ED registration team.

Extra visits or potentially duplicate medical records might be created for new ambulance arrivals if the same patient is accidentally registered twice, explains Boyer. "The patient access staff may also feel their hard work is going unnoticed if they are being asked to register a patient who they already registered," he says.

At times, the clinical staff discharges a patient before access staff has been able to complete the registration. "When patients are discharged before being registered, this can cause headaches for patient access, as well as the clinical staff," says Boyer.

In this case, patient access is missing out on the chance to obtain accurate insurance, demographic, and address information, as well as an opportunity to identify and collect a co-pay, he explains. "If the clinical staff needs to make a follow-up phone call, they may have no way of getting in touch with the patient, due to the missing information," adds Boyer.

Shift leads created

To improve the communication between the registration team in the ED and the clinical staff at Botsford Hospital, shift leads were created.

"The shift lead is the 'go to' person for the clinical staff to come to, if there are any potential problems," explains Boyer.

Each shift lead carries a portable phone, and the name and number for the shift lead is made available to the clinical staff. The shift leads and clinical managers meet monthly to discuss ongoing issues and process improvements in the ED, says Boyer.

Members of the registration staff feel a greater sense of appreciation, and clinical staff knows they always have someone who can resolve any potential issues, says Boyer. "Best of all, with the constant interaction at the monthly meetings, any problems between the two staffs are no longer allowed to fester," says Boyer. "The group works more like a team, rather than separate units."

SOURCE

For more information on communication with clinical areas, contact:

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EXECUTIVE SUMMARY

If communication problems occur between registration and clinical staff, patients might be registered twice or discharged before registration can occur. To avoid these problems:

- Designate a shift lead as the "go to" person for registration and clinical staff.
- Give clinical staff a phone number to call if a problem occurs.
- Hold monthly meetings with registration and clinical managers.

Denials on the rise for radiology claims

Payers are asking for more authorizations for high-dollar radiology procedures, and claims denials are resulting, reports **Stephen Hovan**, executive director of patient fiscal services at The University of Tennessee Medical Center in Knoxville, who adds that his department is seeing a 75% increase in authorizations for radiology processes.

Claims denials occur due to the physician failing to obtain an authorization, being unaware that authorization is required, or authorizing the incorrect process, reports Hovan.

EXECUTIVE SUMMARY

Payers are asking for more authorizations for high-dollar radiology procedures, and claims denials are increasing. To obtain necessary authorizations:

- Implement technology to identify radiology tests needing preauthorization.
- Delay or reschedule procedures if an authorization hasn't been obtained.
- Have technicians notify registrars of changes.

"We are in the process of implementing a rework, where the hospital will be acquiring the authorization," says Hovan. "We will also be generating the order that allows us to verify the medical necessity and the insurance, along with the precertification for the physician." This order will be faxed to the physician, who will sign it and send it back to the patient fiscal services department.

"With the advent of ICD-10 comes complexity of coding. We are investing in technology that allows for the auto verification of insurance, precertification, and medical necessity," says Hovan. The technology will cost $120,000 per year, with an implementation cost of $80,000.

Process changes needed

Multiple payers have increased the required authorizations for radiology procedures, says **Kathi Berzai,** director of access services at Memorial Hospital of South Bend (IN).

"Our director of managed care services keeps us well informed of our payers and the new requirements," she says.

Radiology claims denials often result from add-on procedures ordered for the following day from the emergency department, says Berzai. In some cases, physician's offices state they have contacted the payer, which told them that no authorization was necessary. "Our current process is to contact the physician offices for the tests requiring preauthorization," says Berzai. "We relay to the offices that we are unable to give the necessary clinical information to secure preauthorization."

The department is searching for new technology to identify the radiology tests needing preauthorization and identify whether a preauthorization has been secured. "Currently, our registration staff is responsible for the follow up of preauthorization," says Berzai. "We are considering moving that process to our centralized scheduling department."

Obtaining radiology authorizations is difficult if outpatients have been sent directly from an urgent care center in the middle of the night or a weekend, or early in the morning after being discharged from the hospital's emergency department, says **Doug Mast**, support services manager of the Radiology Department at Moses Cone Health System in Greensboro, NC.

"Urgent care center staff are not used to obtaining prior authorizations," says Mast. "When they come from within our own ER, there isn't time to obtain the authorization prior to the study being completed."

Increase in two areas

Mast has seen an increase in the number of payers requiring prior authorization and the number of exams for which they are requiring prior authorization.

"It's not just the private sector payers, either," he says. "North Carolina Medicaid requires prior authorization, and I do believe Medicare is heading in that direction as well."

The department has made process and procedure changes to address this issue, with schedulers now gathering insurance information at the time of scheduling. Staff members follow up with the ordering physician to ensure the authorization is received prior to the exam, and they will reschedule the patient if an authorization is not received prior to the exam, says Mast.

"When a patient presents to be registered, and they present a different insurance card than what was previously used, that could impact the need for an authorization," notes Mast. *(See related stories on denials involving mismatches, p. 114, and reversing claims denials, p. 114.)*

SOURCES

For more information on preventing claims denials for radiology procedures, contact:

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Department gets ahead of `mismatch' denials

Annual radiology total is $2.5 million

Almost all private plans now require authorizations for radiology services, reports **Richard J. Suszek**, director of patient access at Barnes-Jewish Hospital in St. Louis, MO, and Missouri Medicaid began requiring authorizations in July 2010.

"The only payer not requiring authorizations is traditional Medicare, and that may change as well," says Suszek.

The most common reason for radiology denials is the "mismatch," when one particular scan was authorized but a completely different scan was performed, says Suszek. "The amount of radiology denials for mismatches is about $2.5 million on an annual basis," he says. "Typically, without contrast material was authorized, and with contrast material was performed."

Getting the correct CPT-4 codes to match throughout the process is key in reducing the risk of denials in this area, he says.

The department is making significant work flow changes and investments in personnel and technology to avoid these denials, reports Suszek. "We plan on creating a separate department, first within radiology, to make sure we get ahead of the issue," he says. "We will hire about four FTEs just for radiology, as well as spend another $250,000 in purchased services for technology support from an outside vendor."

Here are three changes being made:

- Starting with scheduling, registrars will ensure that a correct pre-certification has been obtained prior to the patient's arrival.
- Late add-ons and walk-ins will go through a similar, but more expedited, process.
- In some cases, a patient's procedure will be delayed or rescheduled if an authorization has not yet been obtained.

Hold technicians accountable

The number one reason why claims are denied for radiology procedures at Moses Cone Health System in Greensboro, NC, is that the examination performed doesn't match what was authorized, according to **Doug Mast**, support services manager of the radiology department.

"We had a real learning curve with our physician community, in getting them to order the correct exam to begin with," says Mast. "In our facility alone, there are over 2,000 different exams that can be performed."

Exams might be ordered incorrectly by the ordering physician or the radiology scheduler. "With such a large volume of exams, it's tough to know the ins and outs of every exam," says Mast. "An exam may be changed by the tech when the patient is on the table."

A technologist might change an exam based on the history received from the patient or based on findings during the originally scheduled exam. For example, a CT of the abdomen might be ordered, but the patient says the pain has moved to the pelvic area, or a CT of the abdomen doesn't highlight an entire organ because of the patient's anatomy, so a CT of the pelvis is added.

Similarly, a cardiac CT scan might be ordered instead of magnetic resonance imaging or a CT scan instead of an ultrasound for better image quality. "Technology is always changing," says Mast. "It is almost impossible for a primary care physician to keep up with the changing exams and exam protocols."

Regardless of the reason, the technician needs to notify prior authorization staff of the change and be more aware of the business side of healthcare, says Mast. To address this issue, access staff have educated technologists about the need for prior authorizations. "We had buy-in from radiology leadership to hold folks accountable," says Mast. "We consistently followed up with personnel when there were mistakes. We showed the tech the error and also included the dollar amount we lost as a facility." ■

Regain lost revenue due to claim of no auth

Correct inaccurate information

Claims denials at The University of Tennessee Medical Center in Knoxville have increased 20% to 30%, particularly from major payers including The Blue Cross and Blue Shield Association, United Healthcare, and Humana, according to **Stephen Hovan**, executive director of patient fiscal services.

Many claims are denied based on inaccurate

information, such as the payer claiming that an out-of-network authorization or referral is required when the patient is in-network, or a payer denying an emergency department claim because no authorization was obtained, when one isn't actually required, says Hovan.

"In-network physicians are being excluded by the payer for authorization, and the service is being denied because no authorization was obtained," he adds. In some cases, an authorization is obtained and verified as correct in the payer system or over the phone, and the claim is later denied for an incorrect authorization, says Hovan.

Hovan estimates that 2% to 5% of net service revenue is "protected and regained" with good processes, such as thorough documentation that substantiates the need for all charges in the hospital and physician records.

Patient access staff members record all calls with payers, which are indexed at the account and medical record levels. "When the payer denies the claim, we provide the payer with the recorded message or the transcript," says Hovan. "Ninety percent of the time, they reverse the denial and pay."

Even with the recorded evidence, some payers still will request that the denial go through the appeals process. "This whole process is convoluted. It adds additional expense to the healthcare system, along with adding to accounts receivable days — sometimes up to 60 additional days," says Hovan.

If calls weren't recorded, however, Hovan says the department would have a difficult time in getting denials reversed. "Appeals would be required on all cases," he explains. "Our success rate would drop from 90% to approximately less than 50%." ■

Is your patient dealing with high out-of-pocket?

Make it clear you're there to help

More often, patient access financial counselors find themselves in the unenviable position of telling patients about out-of-pocket responsibilities running into the thousands of dollars.

Offering patients an immediate discount if they pay upfront is one good approach, according to **Gail Melingonis**, director of patient access at the University of Connecticut Health Center in Farmington. "Let's say a self-pay patient is going to have surgery, and their out-of-pocket estimate is $10,000. We'll give them that dollar amount, and say, 'If you pay us today, we will give you a 30% discount,'" she says.

Financial counselors must be clear that the $10,000 is an *estimate* of charges, and that there might be additional charges if procedures are added and that the 30% discount would apply to the entire balance in that case, says Melingonis.

If an insured patient has a large unmet deductible, of $2,000 for example, financial counselors do try to collect the entire amount. If the patient says they will not pay anything on the deductible, procedures or surgery isn't held up, however, says Melingonis. "If the patient says they can't pay the entire deductible, we ask them how much they would be comfortable with. We aim for at least half," she says. "If they offer us $20, we may ask for more. If they can't, we would take whatever they offer." *(See related story, p. 116, on copay collection in the emergency department.)*

EXECUTIVE SUMMARY

Provide assistance to patients with large out-of-pocket responsibility by offering discounts and information on coverage options. Help patients by doing the following:

- Ask patients how much they are comfortable paying.
- Explain that charges might change if procedures are added.
- Contact payers to learn how much of the deductible was met.

More accurate estimate

If self-pay patients can't pay an account balance, financial counselors meet with them to see if they qualify for some type of assistance, whether a public program or the hospital's charity care program.

"If they really don't qualify for anything, we tell them that we could set up a payment plan," says Melingonis.

This step isn't done at the point of service, however, because at that point, the actual charges aren't yet known, she says. "We would rather have them get the final bill before we set them up on a payment plan," says Melingonis. "Oth-

erwise, we may over or under estimate what the monthly plan amount should be."

When financial counselors quote a price to a patient, they rely on the CPT code for the procedure that the doctor is planning to perform, she says. If the patient is having a knee arthroscopy, for instance, financial counselors estimate charges based on the CPT code, the fee schedule, the facility fee, and the number of hours the patient will be under anesthesia.

Based on that information, a self-pay patient might be quoted a price of $7,000, but that amount might change because the physician ended up doing a repair during the procedure, she says. "Some patients will call us very frustrated and want to know how much they're going to get charged," says Melingonis.

Financial counselors contact the patient's physician's office to find out exactly what they are planning to do, which gives them more accurate information to base the estimate on. "We try very, very hard to give as much information as we possibly can and make the patient feel that we are helping them," says Melingonis. "They are already being hit because they have a medical issue. I don't want to hit them again with a financial issue."

Deductibles explained

Financial counselors offer to contact the patient's insurance company to find out how much of the deductible has been met. In some cases, patients don't even realize they are responsible for a large deductible before insurance will consider paying anything at all, Melingonis says.

"We find this comes up most often at the beginning of the year, or when insurance takes effect," she says.

Occasionally, an overwhelmed patient will ask a financial counselor, "Why is it so expensive?" In this case, says Melingonis, staff state, "These are deductibles your insurance company set. If you went to any other facility or were treated by another physician, you are still going to have this expense before insurance will consider paying anything."

SOURCE

For more information on helping patients with out-of-pocket responsibilities, contact:

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ED collections surge when asking for copays

Just a couple of years ago, registrars in the emergency department (ED) at the University of Connecticut Health Center in Farmington collected only $100 to $1,000 a month in copays.

"We were doing very poorly collecting any kind of dollars in the ER," says **Gail Melingonis**, director of patient access.

Now, monthly ED collections range from $15,000 to $18,000, which is something Melingonis credits primarily to simply asking patients for their copay.

ED patients were once very resistant to being asked for money, she explains, but this question has become the norm. "There were not too many hospitals in our area asking for those copay dollars, but they're starting to do it now," she says.

Before starting the new copay collection process, says Melingonis, registrars were given training in how to ask for payment, and how to respond to various reactions from patients. These changes were made:

If an ED patient is self-pay, registrars ask for a set amount of $250.

"If the patient says they can't pay it, we always ask them, 'What can you pay?'" says Melingonis. "We ask that staff make a good effort to ask the patient to give us something."

To be sure that registrars have accurate information about the patient's insurance status and copay amounts, the department invested in online eligibility checking.

Registrars now tell patients, "Your insurance is stating that you have a copay of $100. How would you like to pay that today?" "We don't ask them if they want to pay. We ask them how they want to pay," says Melingonis.

Patients no longer seem surprised by this question, because EDs are asking for copays nationwide now, she says. "In the beginning, we had lots of patients tell us, 'You've never asked me for that before,'" Melingonis says. "If a patient does say that, we explain that policies have changed."

If a patient is unable to pay, registrars make sure they are aware that this won't stop them from getting the best possible care.

"If they have no insurance, we can quickly financially screen them and assist them in filling out forms so they can get on Medicaid and also our charity care program," says Melingonis.

When an ED patient arrives, a "quick triage" is performed by the medical staff to determine if the patient is going back right away to a treatment room, in which case the triage nurse does a "mini-reg."

If the patient is quick-triaged and can return to the waiting room, a complete registration is done.

"Under EMTALA [Emergency Medical Treatment and Labor Act] laws, we do not discuss finances until the patient is properly triaged," says Melingonis. "We would ask for payment later, at the bedside or at discharge."

After patients are discharged, the medical staff directs the patient to the discharge desk.

"We ask for the money at that point," says Melingonis. "We have gotten help from the medical staff to lead the patient out to the right place."

Previously, she explains, patients were rarely asked for a copay because a clinical person handled registration. "Since it was a medical person, they didn't focus on the financial aspect. They just wanted to treat the patient, as they should," Melingonis says. "We have put business people in the registration role now."

If the patient doesn't pay anything, registrars document the reason given.

"We hold them accountable for notating, for instance, that the patient stated he didn't have his wallet or that a patient said she can't afford to pay anything at all," says Melingonis. "This way, the information can be tracked."

At times, staff members do struggle in asking sick or worried patients for money, Melingonis acknowledges. "We give staff positive reinforcement by reminding them that this is the new trend. It helps the patient know where they stand, and it's good for the hospital," she says. "They don't always like it, but they know it's their job, and they do the best they can." ■

Referring physicians may misunderstand

The Access Center is the first contact that a referring physician has with the hospital, notes **Bob Potter**, RN, manager of access and preadmissions at University of Colorado Hospital in Aurora. "The first impression is the lasting impression," he says. "Customer service is our sole reason for existing."

To improve relationships between patient access staff and referring physicians, Potter takes these steps:

EXECUTIVE SUMMARY

Referring physicians may have misunderstandings about patient access, such as perceiving compliance with insurance requirements as inefficiency. To establish good relationships:

- Listen to recorded conversations.
- Obtain support from senior physician leaders.
- Explain the need to comply with payer requirements.

• If a complaint involves a patient transfer, Potter reviews the transfer paperwork.

"We can frequently determine if an important piece of information was missed," says Potter. "I can also determine if something else in our transfer process was the source of the problem, such as bed availability or difficulty contacting the attending physician."

• He listens to recorded conversations.

These recordings have been used on multiple occasions to determine the validity of a complaint and can be used as a teaching tool on excellent customer service, says Potter.

"I once had an Access Center specialist who said 'I gave as good as I got,'" says Potter. "I informed her that wasn't exactly what we were trying to achieve in our efforts toward improved customer service."

• He consults involved staff and physicians.

If one of the hospital's physicians is the subject of a complaint, Potter tries to find out what could have been done differently from his or her perspective. "Many times they are apologetic and commit to doing a better job the next time," he says. "With some, however, it is always someone else's fault."

Fortunately, says Potter, there is support from senior physician leaders if there is a problem with a disruptive physician. "Our leaders are very committed to improved access and relationships with the referring community," he adds.

• He corrects misunderstandings about the role of patient access.

"Probably the most challenging part is a lack of understanding by others in the organization," says Potter. "Many misconceptions have been overcome in the past couple of years."

Frequent misunderstandings occur regarding the series of steps involved in completing a transfer, many of which are outside the control of the Access Center staff. "Insurance restrictions are particularly problematic," Potter says.

Members of the Access Center staff are well aware that if claims denials will result if transfers are not done correctly, he explains. Requirements can be very time-consuming, especially after hours, Potter says. "These requirements are not well understood outside the admissions area," he says. "It is perceived as foot-dragging and poor performance by members of the Access Center, which is not the case."

Each month, Potter discusses Access Center functions with the hospital's medical directors group, chaired by the vice president for medical affairs and vice president for patient services. "We discuss how to improve the hospital's reputation in the referring community," he says. "This is a great forum for improved communication and collegiality."

SOURCE

For more information on improving relationships with referring physicians, contact:

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Ask `star' registrars: Educate struggling staff

A team of patient access specialists consisting of top performers, role models within the division, and lead personnel offer a wide range of expertise and experience to registrars at Carolinas HealthCare System in Charlotte, NC, reports **Christina Baugh**, supervisor of PRN registrars and Patient Financial Service Specialists for corporate patient access.

"The benefits have been substantial and an absolute win-win for staff and our organization," says Baugh.

Registrars have markedly improved their communication, leadership, and registration skills and have received focused training in the areas of collections, customer service, and productivity, she says. "We have been able to respond quickly and effectively to training opportunities identified for registrars," says Baugh. "Our specialists and management team bring any concerns to the forefront. We can act quickly to bring our registration staff up to speed."

Here are some benefits of this approach:

• Registrars are more likely to voice their training needs to their peers than to outside trainers.

Typical questions involve how to determine the correct plan codes, how to request the correct amount from a patient, and how to address patient complaints. "Registrars are very receptive to the feedback given," says Baugh. "The rapport and respect that is established by our high performers allows them to work very well with new hires and existing registrars."

• Peer-to-peer education has increased collections and productivity.

"Understanding that 'quality always comes before quantity' is the main thing that we try to instill in new hires," says Baugh. "The speed will come. You must understand what you are doing and why you are doing it."

Baugh gives real-time feedback to help registrars increase collections or answer tough questions from patients, and she is seeing fewer quality assurance mistakes. "There is increased understanding that productivity increases on the backend when we, as registrars, 'get it right' on the front end." *(See related story on teaching "tricks of the trade" to registrars, below)*

SOURCES

For more information on utilizing top performers to train registrars, contact:

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EXECUTIVE SUMMARY

Members of the patient access staff typically are more comfortable asking questions of top performers within the department than outside, and improved collections and productivity can result. To obtain these benefits:

- Give immediate feedback to registrars.
- Share "tricks of the trade" to improve speed.
- Shadow trainees to observe patient interactions.

`Tricks of the trade' should be shared

Show registrars approved shortcuts

Registrars at Carolinas HealthCare System in Charlotte, NC, benefit from "tricks of the trade" shared by specialists within the department, reports **Christina Baugh**, supervisor of PRN registrars and patient financial service specialists for corporate patient access.

These "tricks" are shared via one-on-one training, group sessions, an internal web site, and the department newsletter. Registrars might learn the best possible order to obtain a patient's information for optimal efficiency, or they might learn how to use their "credit reference," a form with all of the patient's information that is printed out to verify, to their advantage.

"They can put anything they need on the credit reference that will help them remember what they need to ask, such as copay amounts, the patient's mother's maiden name, or the patient's e-mail address," Baugh explains.

Registrars also learn about approved shortcuts, such as using the "equal" symbol to populate a certain field, or using the zip code to populate the city, state, county, or country fields. "This increases speed without sacrificing quality," says Baugh.

Use common situations

Patient access specialists often use role playing to get registrars more comfortable with multiple situations involving patients.

"They do this in a non-threatening and safe environment, stemming from their own arsenal of experiences," says Baugh.

Here is how role-playing is utilized:

• Trainees shadow the specialists and other experienced registrars during patient interviews so they can see varied techniques.

"We then review what they feel would work for them, based on what they saw," says Baugh. "This allows the trainee to critique us and to ask questions based on their observations."

• The specialists shadow trainees during patient interactions, so they can fine-tune their approach.

"This has been really helpful in getting the trainees comfortable during the interview and letting them know they have a safety net," Baugh says.

• The specialists use role playing during classroom or staff meeting training to let the registrars see others' styles.

"This gives the trainee and seasoned registrars a chance to laugh at themselves," says Baugh. "They share 'tricks' of their own that may help someone else take it to the next level."

• Staff members use scripts based on role playing as a reference.

"The scripts are a form of role playing that is there when no else is around," says Baugh. "It is an excellent reference that walks the registrar through various scenarios. It allows them to have an answer to a question they may not have thought of."

For example, registrars use scripts on asking for copays in the emergency department, stating, "Your ED copay is $100. You can use debit, credit, check, cash, or a flexible spending account. What would you like to use tonight?" or "How would you like to take care of your ED copay?"

"Saying 'Can you?' or 'Will you?' can decrease your odds of getting payment from the patient," says Baugh. ■

Hear a complaint? Don't jump to conclusions

Hear out your employee first

If a patient complains that a registrar seemed to care only about money, or insists he or she waited way too long to be registered, **Jan Fowler**, director of patient accounting at Saint Vincent Health Center in Erie, PA, makes a point of meeting with the staff person involved to hear their side of it.

Fowler also does some additional research to get the facts. "If it's something quantifiable, such as wait times, I will monitor a log that's kept for these purposes by the front desk greeter," says Fowler.

If the complaint involves a registrar's conduct during a patient's registration, such as their demeanor during co-pay collection, Fowler might sit in an adjoining cubicle to hear the registrar's interactions. Fowler says that by taking this step, she learned that it was unrealistic to expect staff to intuitively know how to collect money from patients, when that wasn't what they were hired to do. "There was a realization that there was a lack of training for some of the staff, so we went back to the drawing board," she says.

Fowler has also observed potentially problematic exchanges, even when associates have no

COMING IN FUTURE MONTHS

- Obtain actionable data from patient satisfaction surveys
- Correct harmful misconceptions on patient access role
- Novel ways to make up for cuts in education resources
- Defend your department against unfair accusations

idea they're offending anyone. In one such case, she fielded some complaints about a registrar who often said, "I pray to God that your medical treatment is successful," because some patients didn't appreciate hearing something religious.

"Working in a Catholic institution, she felt she was doing her duty by saying this," says Fowler. "We had to advise her to stop saying it, which bothered her because she felt it was the right thing to do." Fowler advised her to avoid being specific and simply wish patients "good luck" or state, "I hope your treatment is successful."

Make staff accountable

Barbara Novak, revenue cycle manager at Central DuPage Hospital in Winfield, IL, says, "Whenever possible, we encourage staff to 'own' a patient complaint.

Registrars are trained in how to respond to patient complaints, she says. The key elements are apologizing, listening, and assuring the patient that his or her concerns are taken seriously and will be shared with the department leader, says Novak. "The staff member may send a communication to the supervisor or manager, who may follow up based on the issue and other factors," she says.

To get the actual facts behind the complaint, Novak talks with the patient or family member, the employees involved, and other departmental members. Recently, the following letter was sent to a patient who reported a less than satisfactory experience: "After consultation with our laboratory supervisor, we are working together to review the process surrounding registration timeliness and process flows for specimen drop-offs. We realize that your experience was time-consuming and less than our standard of *Excellent* service at Central DuPage Hospital."

All written complaints are entered electronically into a patient relations software system, which allows complaints to be tracked by departments and type, says Novak. "The leader over that department is often the one who calls the patient and writes the letter," she says.

SOURCES

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