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Access rises from data entry clerk to major player in revenue cycle

Expanded role means growing opportunities

Typewriters were the only way to record a patient's information when **Vicki Sanseverino** began working as an "admit representative" at St. Elizabeth Community Hospital in Red Bluff, CA, in 1983, as there was no computer system in place at the time.

The hospital's patients received services after giving just their name, address, phone, date of birth, social security number, and emergency contacts.

"A form was used with carbon paper while typing, generating a chart," recalls Sanseverino, now the hospital's admissions manager and patient financial services liaison. "A blue card was handmade with the patient's information in a sequential number on the form."

This number became the patient's account number, with staff hand writing information in a log book for tracking purposes. "Our primary responsibility was to get information from the patients or family as quickly as possible and ask them to sign for consent," says Sanseverino.

The admit representatives created the paperwork for charging for other departments completing tests or services, which generated a bill.

At University of California — Davis Medical Center Hospital, a "check-

HAM celebrates its 30th anniversary

This is a special issue of *Hospital Access Management*, commemorating the 30th anniversary of the publication's first issue. Inside, we take a look at the dramatic changes in the patient access role and responsibilities over the past three decades. We cover upcoming challenges for access, necessary education and skills, advice on avoiding conflicts with clinical areas and medical staff over the expanded role of access, the reason cross-training has become necessary, and an explanation of how technology continues to change the job of patient access.

We hope you enjoy this anniversary issue, and we look forward to serving you for the next 30 years.

in clerks" recorded only minimal information about patients using a typewriter, such as name and date of birth, and photocopied insurance cards. They would ask the patients to sign admission documents, and they filed these in a file cabinet.

"The access rep's role was limited to that of receptionist, confirming limited patient information, and obtaining signatures on the admission documents," says **Tracy Abdalla**, hospital access services supervisor.

In the emergency department, the access role overlapped with the hospital unit clerk's role. "The hospital unit clerk not only completed the 'check in' of the patient but was also responsible for transcribing medical orders and completing the necessary requisitions for lab or radiology tests," Abdalla explains.

There were no computers in use when **Katie M. Davis**, CAM, became admissions officer at an orthopedic specialty facility in 1985, and all registrations were typed on a triple carbon form. The registrar completed the registration, verified the insurance benefits, and called the insurance company for an authorization. If the patient could not pay their co-pay or deductible, a payment plan was set up based on the full amount owed.

"All of the training received was on the job," says Davis, now assistant vice president of corporate patient access at Carolinas HealthCare System in Charlotte, NC. "There were no specific training classes for registrars."

A typical day would include working on pre-registrations for upcoming surgeries, says Davis, and every day a different person was assigned to make bed assignments for patients being admitted. One person was responsible for taking calls from the physician's office and logging in upcoming surgeries on a paper form.

"We were expected to be able to work in any area when needed," says Davis. "We also relieved the switchboard for lunch and supper."

Much info gathering

Today's access staff members are required to obtain and input a multitude of information, to ensure claims are paid and state and federal requirements are complied with. They're also required to provide patient education and give handouts on consent of admissions and treatment, advance directives,

EXECUTIVE SUMMARY

The role and responsibilities of patient access professionals have expanded dramatically in the 30 years since the first issue of Hospital Access Management was published. Staff members have gone from recording minimal information manually to becoming an integral part of the overall revenue cycle. Some major changes to watch for:

- Access staff will play a role in preventing decreased hospital revenue.
- Processes for checking medical necessity will become more stringent.
- Auditing of registrations will target prevention of claims denials.
- Education will focus on insurance billing, collections, claims processing, public assistance programs, computer training, and web-based technologies.

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notice of privacy, charity and discount policies, and patient rights and responsibilities, notes Sanseverino.

Registrars scan all documents, photo identifications and insurance cards, verify eligibility, and obtain authorizations, says Sanseverino. Access staff also collect at the point of service, discuss the patient's responsibility and their ability to pay, and screen patients for assistance. "We generate the paperwork for a chart or face sheets with labels and arm bands for patients, while adhering to registration and wait time goals," she says. "We do all this with speed and accuracy, and provide high-quality customer service at all times."

At one time, registrars were expected to obtain only the patient's insurance information so the claim could be billed, says **Lauree M. Miller**, director of patient access at Catholic Health Initiatives in Lincoln, NE. Now, staff collect demographic information, verify insurance eligibility, audit for Medicare as Secondary Payer, and obtain occurrence codes. "We are doing much more information gathering. Accuracy has become significantly more important," Miller says. "It's almost like the back end has slipped across to the front end."

Because patient access is being scrutinized more by billing areas regarding registration accuracy, staff members are doing more verification of insurances and addresses upfront. "We are working more on getting good data from the get-go. We no longer wait until the claim gets denied or we can't get an address," Miller says.

All of these developments mean new opportunities for growth in the patient access field. "It has evolved from a data entry position into a more professional career," says Miller. "A strong thought process is needed in terms of creating account numbers and fixing things such as statuses. We are really getting the medical record started."

Included at table

Miller says patient access is more often included in multidisciplinary teams, such as the newly formed Patient Access Steering Committee she leads. "Patient access is invited to the table a little bit more than in the past," she says. "We need to raise our hand to provide input."

Radiology throughput was the committee's first initiative, and the team is now focusing on short stay surgery throughput. "One of the things we've done is a 'walk in my shoes' program," Miller says. "Sometimes, we don't have a good appreciation for the importance of each others' work." *(See related stories on on future challenges for access, right, financial aspects of the access role, p. 4, and essential skills for access, p. 4.)*

SOURCES

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These challenges in access' future

Resource management is key

Doing "more with less" is a major challenge for patient access leaders, both now and in the coming years. **Lauree M. Miller**, director of patient access at Catholic Health Initiatives in Lincoln, NE, expects this challenge to grow when healthcare reform initiatives are implemented in 2014, due to decreased hospital revenue.

"We expect all payers to be at the Medicare rate, which is not very high," Miller says. "Patient access needs to 'think out of the box' to be successful in keeping the doors of the hospital open." Here are other changes in store for patient access:

• Processes for checking medical necessity will become more stringent, as payers require more documentation to approve services.

"We are already seeing authorizations and precertifications becoming tighter," says **Tracy Abdalla**, hospital access services supervisor at University of California — Davis Medical Center Hospital. "We have to get approval for high-dollar radiology procedures in advance, or it's an automatic denial."

There is the potential for delays in services, adds Miller. "Physicians won't be able to order anything they want to have done any longer," she says. "We need to make sure we have our ducks in a row before

we see the patient."

Due to this development, communication with clinical areas about the revenue cycle has become much more important for patient access. "If we try to do point-of-service collections in the ED, nursing staff could care less — unless we communicate the value to our financial bottom line," Miller says.

• Auditing for accuracy will target claims denials.

"We've been auditing registrations for 10 years. We had to pause and say, 'Are we auditing the things that really matter?' says Miller. "We need to put our resources in the right places."

For example, registrars are expected to use the U.S. Postal Service abbreviations for street addresses, but spelling out the addresses wouldn't result in a denied claim, she explains, whereas identifying the wrong payer would.

• Management of staffing resources will become increasingly important.

"It takes more resources to register a patient than in the past, but our reimbursement is going down," says Miller. "We will need to look closely at how that equation looks, going forward."

Catholic Health Initiatives' four Nebraska hospitals are beginning to regionalize the work of patient access with centralized scheduling. "We can be more productive and more efficient with a regional team, instead of having four teams in each hospital," explains Miller.

• New systems will be needed so patient information can be accessed by other facilities.

"We already have an electronic health record in place. We are now working on getting to an enterprise master patient index," reports Miller. The goal, she explains, is to have patient medical records accessible to health care teams in other cities.

"Standardizing our upfront processes is critical, in order for those interfaces to happen, so they have access to those records," she says.

However, Miller says that she doesn't believe patient access will ever go truly paperless. "You can have registration kiosks, but you still have to have somebody face to face," she says. "The people part will always be there." ■

Access must have financial know-how

Process has moved upfront

In many organizations, financial counseling processes have moved upfront and are now the responsibility of patient access.

"We don't wait until the patient goes to bad debt before we have those conversations," says **Lauree M. Miller**, director of patient access at Catholic Health Initiatives in Lincoln, NE. "We do it proactively, so patients can plan for their expenses related to those services."

Access services representatives at University of California — Davis Medical Center Hospital are highly trained individuals who are responsible for ensuring that the patient's account is financially secured prior to discharge, says Tracy Abdalla, hospital access services supervisor. To accomplish this, staff members complete charity care screening and assist with applications for county or state public assistance programs. "Staff are not only taking on the financial counseling role of the hospital's process; they are also asked to take on part of the role of the public eligibility worker," says Abdalla. Staff members are well-informed about billing processes and understand that incomplete or inaccurate information causes claims processing errors, denials, and decreased reimbursement, according to Abdalla.

One of the primary changes in the access role is the financial follow-up done on a patient account, she says. Over the years, she says, patient access has discovered the need to financially secure the account upon arrival of the patient. "Without this, we're faced with the more difficult task of attempting to obtain and correct information after the patient's discharge," says Abdalla. "This has proven to be ineffective. It has limited our ability to remain financially secure."

For a facility to be financially viable, says Abdalla, the patient access role will need to be heavily focused on the medically indigent population. "With the increase in healthcare costs and related facility expenses, it's imperative that the access representative be focused on the accuracy of each registration and financially securing the account," she says. ■

Access staff members tap skills of the future

Decades ago, a registrar needed a thorough understanding of medical terminology to do his or her job

"The access rep would often work as the hospital unit secretary, transcribing medical orders and completing test requests," says **Tracy Abdalla**, hospital access services supervisor at University of

California — Davis Medical Center Hospital.

These roles often were intertwined, but now are separate and more specialized. "The access rep no longer needs a thorough understanding of medical terminology," says Abdalla. "They no longer need to be focused on those processes related to the clinical care of the patient."

Instead, registrars need to get patients into the computer system as quickly as possible with all the necessary information, meet all requirements and ensure a "clean" claim, says **Vicki Sanseverino**, admissions manager and patient financial services liaison at St. Elizabeth Community Hospital in Red Bluff, CA. "As a result, we can increase the amount of registration staff and decrease the amount of billers," she says.

Access needs effective processes to monitor claims denials data, says Sanseverino, and registrars must understand the laws, rules, and regulations associated with compliance. "Training is key to ensure our employees are confident and competent in delivering this information during the registration," she adds.

Abdalla predicts patient access education will focus on insurance billing, collections, claims processing, public assistance programs, computer training, and web-based technologies. Computer skills have become extremely important, she explains, because the work of patient access is completed in a variety of systems.

"The use of the web and web-based technology has exploded," says Abdalla. "This will continue to grow, forcing today's staff to remain on top of these changes if they wish to remain effective in their positions." ■

Clinical conflicts due to new access role

"Can you do this for us?" It's a common question fielded by patient access managers from clinical areas.

"In fact, this can be asked several times during one shift," says **Barbara Snodgrass**, patient access manager at Mount Hood Medical Center in Gresham, OR.

Patient access personnel accommodate many requests, she adds, some of which have nothing to do with their role in the hospital. Being cooperative helps to build team relationships and improve patient care, notes Snodgrass, but at the same time, clinical and patient access roles vary in innumerable ways. "Misunderstanding the needs or abilities of another department can arise," she says. "We do have to say 'no' or 'we can't' to some clinical requests. Conveying this to the clinical teams requires a diplomatic response."

Patient access often are looked at as clerks or secretaries, says Snodgrass, so when you are asked to do things that aren't specific to the revenue cycle role, the clinical team might not understand why you aren't able to assist. "Sometimes, you just need to explain what the role of access is," she advises.

If a clinical manager asks you to put labels on a patient chart or file paperwork, for instance, you could suggest that volunteers could be utilized on the unit instead of patient access. "The danger of agreeing to a task that is outside of the access role is that staff could end up overwhelmed and off track," warns Snodgrass.

She recommends stating, "We want to help. There are times when it just isn't possible for us to. This isn't to say that the need does need to be met, but it might be that the assistance is better met through another department."

Snodgrass says, "It is absolutely common for patient access and clinical areas to be at odds. I have seen it a lot. Don't shy away from having difficult conversations with your clinical partners." Here are actions by clinical areas that can cause tension with access:

• Members of the access staff are overwhelmed because clinical areas are booking tight appointments.

"With so many patients coming in the front door, clinical areas may not have any concept that other departments are booking appointments at the same time," Snodgrass says.

If this problem occurs continually, you might need to go up the organization's chain of command to get it resolved. "At some point, you

EXECUTIVE SUMMARY

Conflicts with clinical areas often occur due to misunderstandings regarding the expanded role of patient access.

- Don't agree to help with tasks outside of the access role.
- Suggest that volunteers help with clerical tasks.
- Specify what information is needed to register a patient.
- Use technology implementations as an opportunity to educate.

have to say, 'We don't want to drop our level of service. How are we going to meet the needs of our patients?'" says Snodgrass.

• Inaccurate or incomplete information is given.

A labor and delivery nurse might tell a registrar the patient's first name is Kathy, when her legal name is actually Katherine, or the nurse might fail to obtain the patient's correct date of birth. "Nurses should be prompted on what information you really need to register the patient," she says. "It is really important to clarify so you don't have to call down again."

• A nurse gives a registrar the name of an unfamiliar physician in a rushed manner.

This rush can cause a registration error and a subsequent claims denial. "Patient access may not be familiar with all the physicians servicing the patient on that unit," says Snodgrass. "We really need that information provided carefully so it's accurate, or we are just slowing down the process." *(See related story, below, on using technology implementations to improve communication with clinical areas.)*

SOURCE

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New access technology? A golden opportunity

Open up a dialogue

If your hospital is switching to an electronic medical record (EMR), this change is an excellent opportunity to start a much-needed dialogue with clinical areas.

"It opens up a whole new way of looking at things. You have the chance to throw out old traditions that aren't working and resolve some important issues," says **Barbara Snodgrass**, patient access manager at Mount Hood Medical Center in Gresham, OR.

All of Mount Hood's departments are meeting to discuss the implementation of an EMR. "You need a lot of education between the departments, including access, so everyone understands how this new software is going to work," she says. "You don't want the patient to pay the price for a lack of communication."

For example, clinical staff members specified at exactly what point tracking boards are updated to show the patient is ready for discharge, and patient safety issues were discussed regarding clinical staff printing out their own patient labels for lab draws or wristbands, instead of waiting for patient access staff to do so. Questions such as "Are there time constraints for the clinical staff to do this?" and "Do we need more patient access staff to accommodate the new changes?" were addressed.

"Small changes can have a big impact," says Snodgrass. "It is vital to re-establish roles and responsibilities so everyone can be on the same page."

Decisions need to be made about whether nurses or registrars will enter appointments in the EMR, she adds, which brings up the question of whether additional training is needed for either area. "There may be something that patient access can do to help the nurse set up the orders so that the process is seamless for the patient," says Snodgrass. She suggests you take these steps:

• Be clear about every step in a process.

"Talk everything through. At what point in the process is an order is going to be faxed and by whom?" advises Snodgrass. "Don't make assumptions on either side."

• Have joint meetings when rolling out a new process or technology.

During the planning process for opening a new children's hospital, Snodgrass gave input on customer service from a patient access standpoint. "One issue that came up was how much space is needed for an area where an upset patient can meet with a patient advocate," she says.

• Address technology glitches.

Software problems can cause tension between clinical areas and access, as when a patient's surgery is scheduled on one system but the pre-surgery blood work is entered into a different system.

"There may be duplicate accounts because the software isn't interfacing well," says Snodgrass. "That sets you up for a lot of blame going back and forth — something clinical and patient access staff don't want." ■

Stop misconceptions on patient access role

Respect is the issue

When a trauma patient arrives via ambulance, access services staff must obtain information quickly, before the patient is taken for diagnostic tests or given medications, which make them drowsy.

"Medical staff will oftentimes interrupt the registration staff or cut them off completely and make them leave the room," says **Kimberly Ablog-Shapiro**, access representative supervisor for the night shift in the emergency department (ED) at University of California — Davis Medical Center. "Medical staff has a way of making access services staff feel inferior by not acknowledging them," she adds. "Staff complain that they are 'talked down' to, as well."

There is often little to no communication between access services and medical staff, says Ablog-Shapiro, noting that ED registration staff use two computers in each pod to process registrations. On several occasions, registrars left their computers to make a copy or have the patient sign something, and they returned to find a physician using the computer.

"He or she has closed out all of the open windows the registration person was working in, thereby losing all of the information," says Ablog-Shapiro, who adds that this problem occurs even though there are ample computers available for medical staff.

Registration staff sometimes have "extreme difficulty" with social workers when trying to obtain information that identifies an unconscious patient, she adds.

"The worst one, in my opinion, is when bulletins come out about anything to do with the ER. There is never any mention that we are a part of the ER as well," says Ablog-Shapiro. This problem occurs even though access staff work exclusively in the ED and work directly with patients and medical staff, she explains.

"We provide a valuable service to the patients in the community and the entire hospital as a whole, including the flow of patient care, medical records, billing, claims, and clinic referrals," she says.

To correct misconceptions about access, Ablog-Shapiro suggests having medical staff "cross-train" through every aspect of registration, with particular focus on how the beginning of the process affects billing and payment.

"An actual 'cross-training' session might not work because of schedules and how busy the ER is," acknowledges Ablog-Shapiro. "But leaders should provide medical staff leaders a detailed account of everything we have to do, beginning with the patient presenting to the ER and ending with revenue capture." *(See related story on obtaining respect from medical staff, below,)*

SOURCE

For more information on misconceptions about patient access, contact:

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EXECUTIVE SUMMARY

Medical staff might convey a lack of respect for patient access professionals, which can hurt morale.

• Provide education on how registration affects billing and payment.
• Give a detailed account of what access does.
• Identify the skills required of access staff.

Access staff are not "expendable"

Some medical staff members might view access services staff as "expendable" and unimportant to the flow of patient care outside of entering information into the computer, according to **Kimberly Ablog-Shapiro**, access representative supervisor for the night shift in the emergency department (ED) at University of California — Davis Medical Center.

"If medical staff completely understood that we are more than just 'paper pushers,' they would come to value each employee," says Ablog-Shapiro. "They would understand that what we do ultimately affects revenue for the hospital."

Educate medical staff on how correctly and thoroughly registering a patient impacts almost every other major department in the hospital, she advises. "Access staff completely understand their role, in that they are not to interfere with patient care," says Ablog-Shapiro. "They all have tremendous respect for medical staff and the part they

play in saving lives."

However, she adds, the skills of access staff are "not something to be taken lightly" and require expertise in piecing together and discerning scattered bits of incomplete information while adhering to federal regulations and hospital policies. Policies are constantly being updated and revised because of changes in healthcare, she adds. "The frustration of access services staff is that they simply feel undervalued and unappreciated by the hospital hierarchy and medical staff as a whole," she says.

Explain to others that it is a mistake to view access staff as "expendable," recommends Ablog-Shapiro. "These people understand their jobs, and it is not an easy process to replace, rehire, and train new staff," she says.

While the "basics" of registration tasks are simple enough to do, says Ablog-Shapiro, "more than that, it is the ability to understand how important every bit of information they process affects the entire hospital or health system." ■

Provide education on new access role

Invite others to observe your staff

Many hospital associates believe that registration staff simply sit at their desk and greet patients, reports **Barbara Blum**, director of access, admitting, and registration at MedStar Health in Columbia, MD. "They have no idea what the registration staff's responsibilities include," Blum says.

Other departments might not realize that registration is a big part of the hospital's revenue cycle, for example, or that staff work with more than 100 insurance plans.

"A goal is to verify upfront that the insurance is active. This allows a clean bill," says Blum. "Registration is a big part of upfront collections. If not collected upfront, it can result in bad debt."

Staff members in other hospital areas don't acknowledge the work of patient access because it's not understood, says Blum, but they are quick to blame access staff for mistakes they didn't make. "If there are any problems — incorrect labeling, an incorrect name in other systems, or delays in patient care — the assumption it is a registration error," says Blum. "This results in poor employee satisfaction and morale."

Blum says staff in other areas might offer to help when the registration system goes down with the attitude, "What could be so hard? Your staff are just clerks." To this, Blum responds, "It is not clerical data entry. You would need knowledge of insurance and the registration system."

Give presentations

Blum recommends giving a short presentation at a monthly manager's meeting on one of these topics:

- data captured on upfront copay collection for self-pay patients;
- your department's progress toward a goal of completing a registration within a certain number of minutes;
- the number of patients registered in an hour;
- claims denials due to lack of authorizations.

Blum suggests inviting managers to spend some time in the emergency department or outpatient registration areas. "In some areas, access sees over 100 patients in an eight-hour period," she says. "They will see that we are still smiling, collecting copays, verifying insurance, and identifying patients."

Inform others that you deal with every aspect of the hospital system, from data entry to diagnosis codes to complex financial problems, advises **April C. Robinson**, MBA, MHA, patient access manager at Palmetto Health Richland in Columbia, SC. "We are the first department that meets the patients upon their arrival at our facilities," she says. "We are also the first and last link in the revenue cycle chain for the hospital system."

Robinson suggests creating an interdepartmental team with leaders and staff members from nursing, the medical staff, patient access, pre-registration, patient billing, environmental services, and any department that is a part of patient care.

"This team should be tasked with the goal of learning about the job functions of each department," she says. "Everyone can learn how to fully utilize all talents, to provide the ultimate patient care experience." *(See related story, p. 9, on how access affects satisfaction scores.)*

EXECUTIVE SUMMARY

Educate other departments on what patient access staff members do on a daily basis to avoid being unfairly blamed.

- Give presentations at manager's meetings.
- Invite managers to spend time in registration areas.
- Create an interdepartmental team.

SOURCES

To obtain more information on educating members of other departments on the role of patient access, contact the following persons:

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Remind clinicians about satisfaction

Members of your patient access staff probably are reminded often that the clinical side of patient care is more important than gathering the proper information.

"We are often overlooked by everyone. We rarely get the recognition that is deserved for the magnitude of the work that we perform," says **April C. Robinson**, MBA, MHA, patient access manager at Palmetto Health Richland in Columbia, SC.

However, a lack of respect for patient access can affect the overall care received by the patient, according to Robinson. "Patient access reps are not always respected as competent and skilled employees," she says. "Yet they are at the forefront of a patient's hospital visit. They set the tone for the entire visit."

With the healthcare industry changing to a pay-for-performance system, adds Robinson, patient access departments are now charged with the task of initiating a positive visit for all patients. "Although the clinical aspects are very important to patients' visits, registration drives the entire process until the patient gets their final bill," she says. "We are often called upon by ancillary areas to resolve billing issues."

Other departments seem to think that patient access representatives simply fill out demographic information to log patients into the hospital system, adds Robinson. "The patient access services department is often viewed as just an entry-level job that anyone with a high school diploma can perform," she says.

Remind others that patient access staff are knowledgeable on federal requirements for patient privacy and identify theft prevention, Medicare and Medicaid regulations, and commercial insurance policies, Robinson says. Inform people that your staff are excellent multi-taskers and problem solvers with strict time constraints, she advises. Tell them staff navigate through multiple computer systems as they schedule and reschedule complex patient appointments for nurses and physicians, she says. "They must have the ability to not only be great customer service reps, but also to perform their task accurately within three to five minutes per patient," Robinson says. ■

Cross-train staff for 'good turnover'

Well-trained registrars moving to a different area of the hospital might be something you'd never wish for, but this process is encouraged by **Colette Lasack**, MBA, executive director of revenue cycle at Gundersen Lutheran Health System in La Crosse, WI.

"We are very open that a lot of our jobs are more entry-level jobs for the organization. We take a lot of pride in growing people up and out of here," she says. "We embrace the fact that we are a feeder system. We don't want people to think they are trapped in patient business services forever."

Having former patient business services staff positioned in other hospital areas helps the department overall, according to Lasack. "If we have people with revenue cycle knowledge in other areas, it only makes us stronger," she says. "When we have to roll something new out, we have planted seeds out there that can help us."

Six years ago, a career ladder was implemented in patient business services, with certification and education requirements clearly outlined. "We wanted people coming in to say, 'I'm in a place

EXECUTIVE SUMMARY

Provide training in other areas to improve staff morale, even if this training results in staff leaving patient access, as this process expands the number of hospital employees with revenue cycle knowledge.

- Encourage members of your staff to work in different roles.
- Offer job shadowing.
- Allow staff members to work from home if appropriate.

that believes in my growth,'" says Lasack. "When a job opens up, they're ready to move to that level, whether in our department or other parts of the hospital."

The department averages 2% to 5% turnover annually, reports Lasack, with staff moving to information systems, compliance, nursing, and human resources, "but it's good turnover. It's a different mindset."

There is no better way to get staff to understand the overall revenue cycle than to have them work in different roles, she explains. "We encourage job shadowing to satisfy people's interests. This helps them understand how the work they are doing impacts different areas," says Lasack. "If I'm sitting in a hospital admissions office and I get the wrong insurance, what happens down the road?"

After staff work in multiple roles, she adds, they tend to become solution finders rather than just reporting a problem.

"They become better problem solvers. That really helps strengthen our teams," Lasack says. "There's nothing better than having somebody on staff who has worked in at least three different parts of the revenue cycle." *(See related story, below, on how telecommuting can improve productivity.)*

SOURCE

For more information on cross-training access staff, contact:

• **Colette Lasack**, MBA, Executive Director, Revenue Cycle, Gundersen Lutheran Health System, La Crosse, WI. Phone (608) 775-4370. Fax (608) 775-1033. E-mail: CMLasack@gundluth.org. ■

Telecommuting: A new option in access?

Traditionally, a registrar had to be physically present to enter data as patients arrived, but expanded roles have opened up the possibility of telecommuting for some departments.

"It can save the hospital resources, in terms of physical space requirements," says **Colette Lasack**, MBA, executive director of revenue cycle at Gundersen Lutheran Health System in La Crosse, WI. "But the bigger win is employee satisfaction."

Telecommuting allows managers to balance work requirements with the needs and desires of employees, according to Lasack, who adds that higher productivity is required when revenue cycle employees are allowed to work from home. "We expect to see about 30% higher productivity, and we get it," she says. "A side benefit is that we tend to have far fewer HR issues with those working at home than those working in the office."

When the weather is bad, staff can follow up with patients at home, she adds. Currently, a preregistration group works from an administrative building offsite. Those staff call patients prior to their clinic appointments to verify demographic and insurance information. "In the future, we envision these jobs being done remotely from home," says Lasack. Other positions within the revenue cycle already are done successfully from home, including the customer service call center, coding and insurance billing, and follow-up, she reports. "Those working at home are provided company equipment and must have a designated work area," she says. "They must sign our standard contract as to how they will maintain privacy at the home work site."

More patients want to interact with registrars through e-mails, telephone, chat rooms, or texting, adds Lasack, which means that more work can be done remotely. "Being able to interact with patients virtually before the visit, either via the computer or the phone, is an area we definitely see increasing," she predicts. ■

From typewriters to high technology

Registrars had no computers

The "technology" utilized by registrars 30 years ago at Tufts Medical Center in Boston consisted of a typewriter, multi-part forms, a copy machine, and a manual embossing machine to print patient identification cards.

EXECUTIVE SUMMARY

Technology has become an essential tool for patient access departments, and it has dramatically changed insurance verification and patient flow processes.

- Patients are able to schedule appointments, preregister, and pay liabilities.
- Staff can tell in seconds whether a patient's coverage is active.
- Online web access gives copay and deductable amounts in minutes.

"How did we ever get the job done?" asks **Mary Jo Brown**, the hospital's director of admitting and patient registration. "We had no computers, so patient scheduling was done in a book."

There was no advance insurance eligibility checking, as health maintenance organizations didn't emerge in Massachusetts until the mid-1980s, says Brown, and most of the population was covered by Medicare, Medicaid, Blue Cross, and a few commercial insurance companies.

Patient's registration data was handwritten on multi-part forms, says Brown, so it was sometimes illegible with inconsistently used abbreviations. "If the paper was misplaced, so was all of the patient demographic and insurance information," she says.

The patient billing department was the only area with a computer, she reports, with staff using a "keypunch" system to enter billing information. "Daily admission and discharge reports were typewritten, and many copies were made in order to distribute the information," she says.

Daily statistical reports were completed manually utilizing a calculator, says Brown, with the first automated registration database installed at Tufts Medical Center in 1984. "A whirlwind of exciting technology has continued to become part of our work life ever since," says Brown. "We have converted our registration system twice since the original was installed, and we are preparing for a third conversion." Here are some technology changes the department has seen:

• Automated insurance eligibility verification systems give staff up-to-date information at each patient encounter.

"Automatic posting programs help us to save the eligibility data by posting the automated responses right to the patient's account number," adds Brown.

• Electronic bed board systems make the status of each bed "visible" on a computer screen.

"The bed coordinators know just by a glance at the screens which beds are occupied, vacant, dirty, or have a discharge pending," says Brown. "Planning for bed placement becomes much smoother."

• Patient identification bands are placed on the patient's wrist during the registration process, and they are scanned by the bedside nurse prior to administering medications.

"This process provides a direct support to improving patient safety by eliminating medication errors," says Brown. "Upcoming technological advances for patient access will certainly be exciting. I can't wait to see what the next decade brings!" *(See related story on technology tools, below.)*

SOURCES

For more information on technology used by patient access departments, contact:

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Technology tools you must have

Thirty years ago, the Master Patient Index (MPI) used by a hospital's registration and admitting department typically was maintained by medical records.

"This meant that each time we needed a medical record number assigned, we had to call medical records for them to manually look up the number or to assign a new one," says **John Woerly**, RHIA, CHAM, FHAM, a senior manager at Accenture Health Practice, an Indianapolis-based firm that provides technology and consulting services.

Only a handful of hospitals had centralized patient scheduling — a new idea at the time — and insurance benefits were verified by calling the payer and manually recording data in the patient database, says Woerly. "We basically had a simple telephone to answer calls with and make calls. No sophisticated Customer Relationship Management in those days!" says Woerly. "Now, technology is everywhere."

Woerly says that some of the cutting-edge technologies being used by today's access departments

COMING IN FUTURE MONTHS

- Avoiding fines for non-compliance with privacy regs
- Answers to tough financial questions from patients
- Responses for the most difficult patient complaints
- Strategies to stop needless revenue loss at your hospital

are web-based technology to allow patients to schedule their own appointments, access their own medical records, request referrals, pre-register and pay liabilities, and patient liability estimators to provide patients with charges. Here is the technology that most of today's patient access departments are using, according to Woerly:

• Enterprise Master Patient Index (EMPI).

This technology assigns patients, insurance plans, and care providers with unique identifiers such as regional or enterprise-wide, and maintains a cross-reference of local identifiers from each participating facility. "It can also store patient demographic, insurance, and high-level visit history data," says Woerly.

• Enterprise scheduling.

This technology allows patient appointments and resources to be scheduled from a single application for such areas as hospital, physician, ancillary departments, and home health. "Systems integrate into the EMPI for access to single-source enterprise patient data and seamlessly integrate with electronic payer connectivity, registration, referral management, and medical necessity checking systems," says Woerly.

• Electronic insurance verification.

This system allows a network of participating payer organizations to be queried, via real-time or batch, to verify a patient's eligibility and benefit coverage. "Most systems auto-populate within the patient's record," adds Woerly.

• Document imaging/scanning.

"This is an information capture and retrieval system that stores patient-centric documents and allows immediate, simultaneous access from multiple locations," says Woerly.

• Workflow management tools.

This tool organizes work by "pushing" role-appropriate online work lists to staff resources in all work phases, such as financial clearance, referral management, registration, and financial counseling. "It organizes and drives work, while reporting on performance indicators," says Woerly.

• Bed management systems.

This technology provides an online "bed board" that shows bed needs for outpatient surgery, emergency department, and other sites, and integrates transport requests, housekeeping workflow, and dietary workflow.

• Customer relationship management.

"This uses a combination of people, process, and technology to provide a host of reporting tools, including patient-specific relationship data," says Woerly. ■

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`Little movement' for salaries in access, but changes are coming

Higher compensation on horizon

Since the onset of the recession, there has been "little movement" in salaries for patient access/registration areas, according to **Tina Williams**, BSHA, MMHC, director of access services at Monroe Carell Jr. Children's Hospital in Nashville. However, this trend could change in the near future, due to developments such as healthcare reform and the switch to ICD-10 coding.

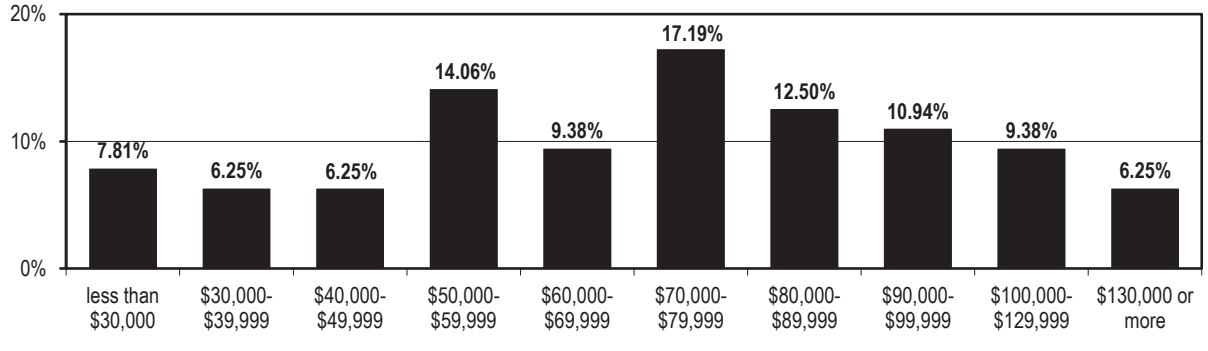
"Access/registration has always been a complicated process, and it is not looking likely to change in the future," says Williams. "ICD-10 will further complicate the process by moving from the current 17,000 codes to approximately 141,000."

With this change, all frontline staff will need to become more educated on the specificity level necessary to schedule and authorize care, says Williams.

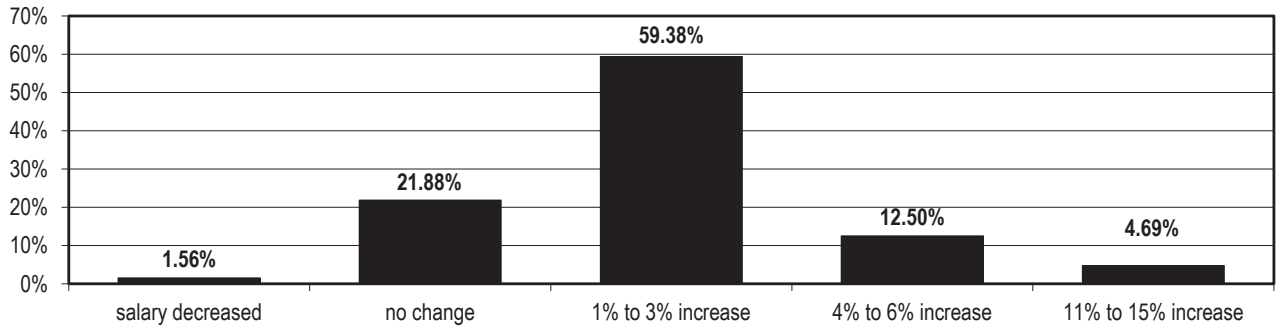
As hospitals and physician practices rely more on their front-end staff to ensure the capture of good demographic and insurance information, the hope is that they will adjust salaries for these individuals accordingly, she explains. "I believe the salaries of coders and utilization staff will continue to rise, as the methods of payment become more complex and detailed," predicts Williams.

According to the *2011 Hospital Access*

What is Your Annual Gross Income from Your Primary Health Care Position?



In the Last Year, How Has Your Salary Changed?



Management Salary Survey, 14% of respondents earn between $50,000 to $60,000, with 20% earning less than that amount. Another 9% earn between $60,000 and $70,000, 17% earn between $70,000 and $80,000, and 16% make over $100,000. Fifty-nine percent of respondents reported a 1% to 3% increase in salary in the last year, and 13% received a 4% to 6% increase. Only 5% received a larger increase of 11% to 15%, and 22% reported no change. *(See charts on p. 1 & 2.)*

The survey, which was administered in September and tallied, analyzed, and reported by AHC Media, publisher of *Hospital Access Management*, identifies some of the factors impacting salaries and benefits in patient access. For the 2011 report, 394 surveys were disseminated. There were 64 responses, for a response rate of 16%.

Other key findings of the survey:

• Twenty-eight percent of respondents work between 41 and 45 hours, and 22% work between 46 and 50 hours. One-third (34%) put in more than 50 hours. *(See chart on p. 3.)*

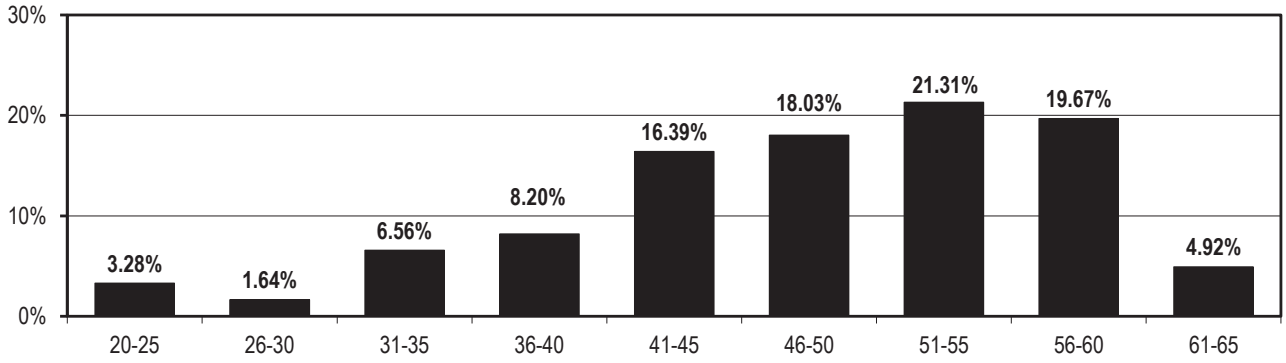
• Fourteen percent of respondents have worked in patient access for three years or less, and 11% have worked between four and six years. Seventeen percent have worked in patient access for 25 or more years. *(See chart on p. 3.)*

• Forty-six percent of respondents were older than age 50. *(See chart below.)*

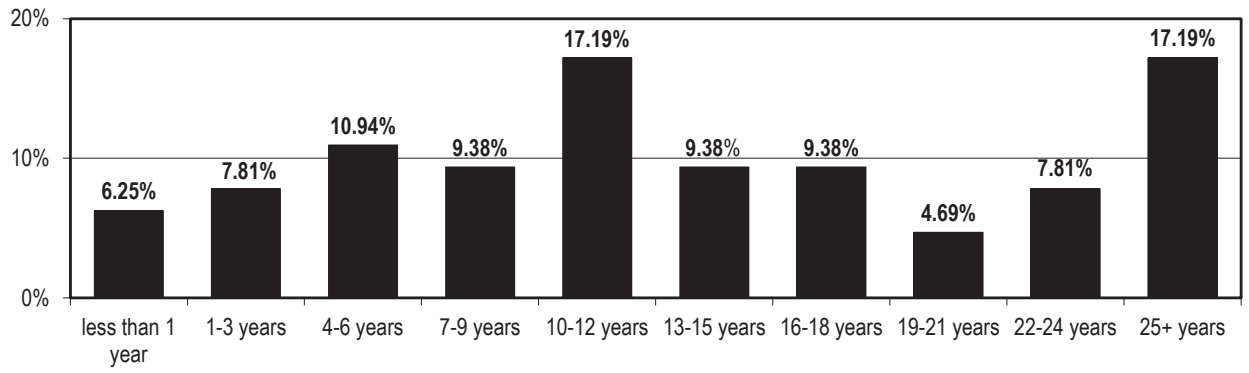
More specialized

Williams says that is too early to tell if the

What is Your Age?



How Long Have You Worked in Your Present Field?



Affordable Care Act will change the registration process enough to affect salaries.

"If anything, I think the career field for access will continue to grow as we get more specialized," she says. "If you are interested in healthcare but not in a clinical sense, access is the place to focus on for the future."

A minimum of a bachelor's degree in healthcare administration is necessary for today's patient access professionals, says Williams, noting that universities across the country have recognized the need to provide specific education in healthcare. "Obtaining a degree in healthcare administration is a valuable asset," she says. "It shows employers that you hold skills to take you from the frontline to the management team."

Understanding business as a whole, with an emphasis on healthcare, sets an applicant apart from others, says Williams. "Also, more and more online and face-to-face ICD-10 educational opportunities are popping up," she adds. "These will be sought after in the coming months and years."

Be "employer of choice"

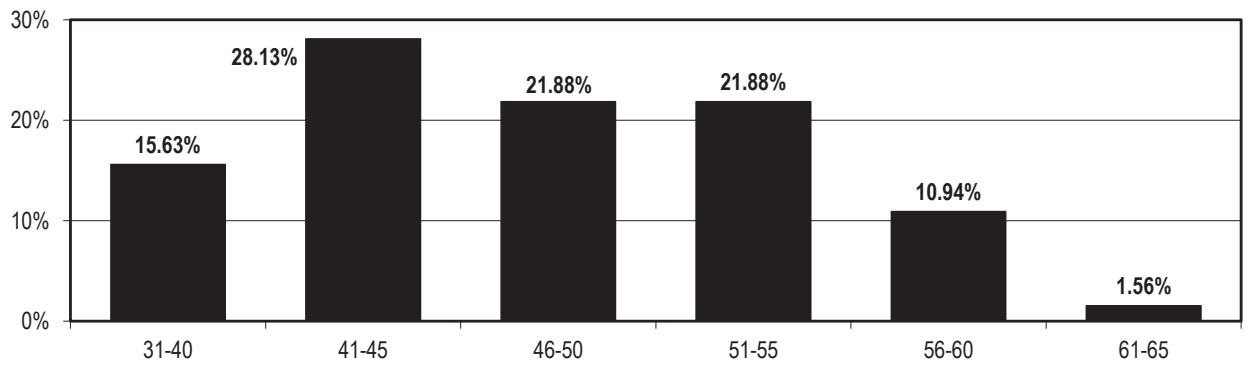
"As we move into the next phase of healthcare, I think leaders are going to have to move from managing to leading," says Williams. In other words, she says, patient access leaders will need to see the organization's vision and connect frontline staff with that vision.

"Without the support and buy in of the frontline staff, we will not be successful," she says.

For this reason, she says, access leaders are going to have to advocate for their staff. This change means not only ensuring that salaries are commensurate with their skill set, but also offering flexible schedules and positive work environments.

"Placing a value on the components of the frontline staff to administration is key to ensuring staff satisfaction," she says. "The need for skilled frontline staff will accelerate in the coming years.

How Many Hours a Week Do You Work?



Becoming an employer of choice will be essential."

Tech skills needed

Patient portals, automated insurance verification and authorization tools, kiosks, and scanned images have made patient access jobs much more efficient, reports **Katie M. Davis**, CAM, assistant vice president for corporate patient access at Carolinas HealthCare System in Charlotte, NC.

"Technology is one of the biggest changes taking place now," she says. "The other big change is that the importance of a highly skilled patient access staff is being recognized as a key to effective revenue cycle management."

Davis predicts that in the coming years, there will be "more and better" technological interventions that will allow patient access to produce nearly error-free work. "In the upcoming years of healthcare reform, patient access will be critical to ensuring facilities are reimbursed," adds Davis.

When Davis first started in patient access, it was one of the most entry-level positions as the hospital. "Now, almost everyone I hire has, at minimum, an associate's degree. Most have a four-year degree," she says.

It is imperative that registrars have critical thinking skills, says Davis, because each encounter with a patient can bring different situations that they must be able to handle quickly and correctly. "The skills that are currently used today will still be in place, but will be refined due to newer technology," she says. "Technology may allow us to either repurpose or reduce staff."

Healthcare reform will directly impact registrars, adds Davis, due to additional skill sets that have to be mastered to ensure compliance with the regulations. "Opportunities to be more involved with financial counseling process will be more available," she predicts.

These new responsibilities are a likely indication of higher salaries for patient access in the coming years, according to Davis.

"We routinely review salaries for similar positions that have the same educational requirements as we require," she says. "I feel that salaries will continue to rise to the corresponding responsibility." ■