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Collections soar to $2.9 million: Cash incentives are the reason

Staff is motivated as a group

At Hendrick Medical Center in Abilene, TX, offering incentives "has impacted our collections tremendously," reports **Berdia Thompson**, admissions supervisor.

Registrars collected about $800,000 in 2003, but this amount increased to $2.9 million by 2011 after additional training was given and an incentive program was started. "An incentive of 3% of total monthly collections is divided among the employees," she says.

Thompson says that an incentive for collections gives registrars "that extra push" to ask patients for money. "Some employees depend on that extra incentive to pay bills. It is more than just a bonus to them; it is their livelihood," she adds.

If patient access employees at Martin Health System in Stuart, FL, collect 5% more than the same month in the previous year, they receive a $50 payment.

"At first, we couldn't figure out what a reasonable increase was every year," says **Carol Plato Nicosia**, CHFP, CPAM, MBA, administrative director of corporate business services. "We chose 5% because that is about what our charges go up every year."

"In a bad economic time, time-of-service collections are even more important," says Nicosia. "The adage 'If you don't get it at the time of service, you probably won't get it,' is even more true."

Because bad debt collections are included toward the collection goal, this

EXECUTIVE SUMMARY

After incentive programs were implemented, collections increased from $800,000 to $2.9 million at Hendrick Medical Center and rose by 40% at Ronald Reagan University of California -- Los Angeles Medical Center.

- Offer payments if collections increase by a certain percentage over the previous year.
- Include uncollected balances toward the collection goal.
- Give incentives to all patient access staff, not only those who collect.

inclusion motivates staff to ask for previous balances. A registrar recently noticed that a patient receiving a discount for an elective cosmetic procedure had an uncollected balance from 2004, and the registrar ended up collecting 50% of this amount, says Nicosia.

"Previous balances are probably 5% of the money they collect, so it's not a huge amount. But if we didn't bring it up, it would not be collected," she says. "Staff tell the patient, 'Before we continue, we have to take care of this outstanding balance.' The patients pay up, then they talk about the current balance."

Employees received the bonus just seven months last year, but Nicosia says it's not intended for the employees to receive the extra payment every single month, because the incentive is for meeting a "stretch goal."

A running total of collections is posted, so staff members know exactly how far they are from meeting the goal. "This really fosters team spirit. Staff can see, 'We have only $2,000 more to go this month, and we'll get our bonuses,'" says Nicosia.

Each year, the hospital's COO asks Nicosia whether she thinks anything should be done differently to obtain even better results from the incentive program. "We have found that this approach takes the least amount of effort and time by the manager. In terms of dollars collected, it's a small amount to pay out," she says. "We get a lot of bang for our buck."

A 40% increase

In the first month after an incentive program was started at Ronald Reagan University of California — Los Angeles Medical Center, collections increased by 40%, reports **Cris De Castro**, CCS, manager of financial counseling for patient access services.

The new incentive program offers admission and registration staff up to $1,500 every quarter, says De Castro. These steps are taken:

• An individual goal is set, based on the specific job duties of staff in the main admission area, the emergency department, pre-registration, and patient financial services.

For example, admission staff and emergency department registration are given a goal of collecting from 20 patients each month.

"This mean they only need to do one to three collections per shift, depending on their work hours," she says. "When we reviewed this new goal with our staff, they agreed that it didn't seem too hard to do."

• Staff members are given a collection scripting tool.

"This helps them approach our patient in a comfortable and professional manner," says De Castro.

Highlighting top collectors

• Previous collections versus current collections are posted.

"We highlight our top collectors for everyone to see. This motivated our staff to do more," De Castro says. "The top collectors in the four areas will be given a gift card."

• Staff members receive training if their goal isn't met.

"We have a high number of staff who were close to meeting their individual goal," adds De Castro. *(See related story on individual versus group incentives, p. 63.)* ■

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Stop hard feelings about incentives

Take a team approach

Giving incentives to individual registrars who met collection goals at Martin Health System in Stuart, FL, seemed like a good idea at first, but it didn't work out too well, according to **Carol Plato Nicosia**, CHFP, CPAM, MBA, administrative director of corporate business services.

The problem is that "several people touch the same account," Nicosia says, so it was difficult to determine who should receive credit for collecting funds. A registrar might do a lot of work determining the amount to collect at pre-registration, for example, but the patient might end up paying a different registrar on the day of service.

"Clearly, there are people who do a lot of important work who don't necessarily get to collect the cash," she says. "If they're working on authorizations, you want them to be part of the bonus."

In addition, says Nicosia, registrars were "gaming the system" by trying to register patients who they knew would owe more out of pocket, she says. "If it is more money in their pocket, they are going to find a way to make sure it comes to them," she says.

Incentives are now given to all patient access employees if the goal is met, which Nicosia says has been much more successful. "We want everybody to try to collect as much as they possibly can," she says.

All FTEs included

If a department doesn't make its monthly collections goal several months in a row, employees begin to doubt their ability to collect, says **Berdia Thompson**, admissions supervisor at Hendrick Medical Center in Abilene, TX.

"They lose motivation and their attempts to collect also begin to decrease," Thompson reports.

If an overall trend of lower collections is observed, employees are given in-services to improve their collection skills. "We also refer to our dashboards to see if a smaller patient volume has affected our collection opportunities," says Thompson. "During the 2010-2011 fiscal year, our department made its collection goals 10 out of 12 months."

Originally, only registrars who collected the money from the patients received the incentive, which led to some patient access employees "picking and choosing" the patients they wanted to register because of the amount due, says Thompson.

"This created uneasy feelings among the other employees," she says. "People who were behind the scenes felt they played an important role in the collections process."

Now, all full-time patient access employees receive the incentive unless their base pay already is higher than their colleagues', such as insurance verifiers who calculate the patient's out-of-pocket responsibility, says Thompson.

"Without estimates, the registrars would not know what to collect from the patients," says Thompson. "Temp employees also get an incentive; however, their portion is calculated at a different percentage." ■

Denial initiative nets $2.5 million

Obtain much-needed revenue

"I'm going to teach you some of the basics of billing and claims management." When **Mary Calloe**, director of patient access services at Cambridge (MA) Health Alliance, said this statement to members of her staff, they weren't too happy about it.

"I got some strange looks when staff thought they were going to become billers," she says. "I explained to them that I was going to show them how the work they did in patient access had a direct connection to the hospital's ability to get paid."

The patient access department's denial management initiative has obtained $2.5 million in additional net revenue annually for the last couple of years, reports Calloe. Staff received training on how to interpret data from payers, and a new claims management system was implemented. *(See related stories on how this tool is used by patient access staff, p. 64, and how a registration quality assurance tool can decrease denials, p. 64.)*

"Denials that are attributed to patient access related

EXECUTIVE SUMMARY

A denial management initiative at Cambridge (MA) Health Alliance has resulted in $2.5 million additional net revenue annually, and adding a nurse/coder has reduced denials for imaging tests by more than 50%. To make claims management part of the patient access role:

- Integrate a claims management system into front- end work.
- Give staff members the chance to correct their own errors.
- Obtain approval to hire an employee with a clinical background.

areas are the lowest of all categories we track," says Calloe. "We have now come full circle. Staff can see a clear connection to their work and are concerned about getting every dollar."

Previously, the department didn't have good data as to the underlying reasons for claims denials, Calloe says.

"We went from having no data to working closely with our IT department and getting a tremendous amount of data," she says.

The reason for a denied claim could be something as simple as an invalid zip code or something more complex, she explains.

"It could be something that is very minute and not intuitive," she says. "It could be that a payer wants something done differently from every other payer."

Patients might change their insurance coverage or have multiple coverages. "That, in addition to new products, in- or out-of-network plans, and wide variations in out-of-pocket expenses due from the patient just keep adding to the everyday challenges," says Calloe.

Clinical expertise

"One of the biggest areas that we were losing money on was high-end imaging services that required a prior authorization," says Calloe. Due to more complex authorization requirements for these tests, it was determined that patient access needed an employee with a clinical background, she adds.

"We were able to support the need for a nurse/coder to help facilitate the information flow between the department and the insurance company," says Calloe. "With a change in the process and the additional skill set, we were able to reduce denials in this area by more than 50%."

Patient access leaders now attend meetings in clinical areas to obtain feedback on payer trends and patient experiences, she reports. "When you talk about it in terms of customer service, it gets providers thinking about the process differently," she says. "We never want a patient to get a bill inappropriately." ■

System gets out more 'clean' claims

More detailed information given

A new claims management system implemented at Cambridge (MA) Health Alliance in 2010 has allowed patient access staff to help get many more "clean" claims out the door, says Mary Calloe, director of patient access services.

"A lot of people think it's just for the business office or billing staff, but we have integrated this into our front-end work," says Calloe. "Staff can look at why things [are denied] from a pre-billing standpoint."

The claims management system helped patient access staff to work collaboratively to increase overall revenue received by the hospital, Calloe says. "It helped them to partner in a different way with the folks that worked in the business office and in revenue integrity," she explains. "We now have a more common understanding of denials and a tool that everyone uses in the same way."

Patient access staff are now asking for a data quality system so information can be obtained real-time during the registration process, which would ensure accuracy during all shifts, including part-time staff who work only on weekends, she adds. "Registrations can occur at many different points of entry. It's not always a defined group of people who are here Monday through Friday," she says. "Often, it wasn't our core staff that were making the repeated mistakes."

Mistakes corrected

The claims management system corrects some mistakes automatically, says Calloe, and staff members are able to correct some of their own errors.

"Historically, that type of feedback did not exist here," she says. "It is not always present in a patient access environment."

Before, staff might have been told a claim was denied because they failed to check eligibility, but the tool gives more detailed information, such as the fact that one reason for eligibility-related denials was that accounts were outsourced to a third party that intentionally was dual billing patients with multiple insurances, adds Calloe.

"Staff are thinking a lot more about our systems and what changes can be made in the flow of information, so we capture things correctly," Calloe says. ■

2 new tools combat denials

Until recently, patient access managers at University of Iowa Health Care in Iowa City performed all quality assessments manually, says

Susan Newton, who is the revenue cycle manager for patient access management and patient financial services.

"The process was labor-intensive, and we made random checks on less than 1% of registrations," she adds.

Ten patient accounts were reviewed on a monthly basis for each member of the staff using established criteria. The managers were looking for incorrect patient addresses or incorrect policy numbers and incomplete Medicare Secondary Payer questionnaires.

The department recently purchased a registration quality assurance (QA) tool with edits focused on preventing claims denials due to front-end errors, such as invalid mailing addresses, incorrect ID numbers, or omission of Medicare for a patient over age 65, says Newton. "There will always be some manual quality checks we will have to perform, but we hope the product will decrease that significantly," she says.

The product will reduce manual checks on patient address accuracy, specific financial classifications, policyholder accuracy, and employer groups and insurance formatting, says Newton. "Each staff member signs into our QA system daily to check for their registration errors," says Newton. "Edits are done either through real-time interface or batch if complete evaluation is needed."

The tool identifies errors due to staff "shortcuts" such as copying patients' demographic information into the policyholder's information on the billing system when this might be a different person, adds Newton.

More frequent checks

Insurance eligibility is verified about 20 days before the patient is scheduled to be seen, but the insurance status sometimes changes in that time window, says Newton.

"We want to check for active coverage much more frequently," says Newton. A new eligibility system was implemented that will check eligibility at the point of scheduling, 20 days out, and several days prior to the date of service.

Approximately 5% of claims are denied, says Newton, and of these, 13% involve the front end.

"Some of the front end denials include coverage terminated, patient not eligible, and ID not found," says Newton. "We expect to see a decrease of approximately 1-2% with the QA registration product." ■

'Wow' patients with unforgettable service

Consider patient's point of view

Before a patient even approaches your registration area, he or she might "expect the worst," according to **Keith Weatherman**, CAM, MHA, associate director of service excellence for the corporate revenue cycle at Wake Forest Baptist Health in Winston-Salem, NC.

"They may feel scared, not just of what is happening to them medically, but also the enormity of the facility — even the parking deck," Weatherman says.

If members of the patient access staff are doing their jobs correctly, they'll make patients feel more at ease, he adds. "I truly believe that we can change their perception of coming to a big, scary hospital," says Weatherman. "We quickly make them feel that things are going to be good for them."

Here are some ways to give patients excellent service:

• Instruct your staff to make eye contact.

This step is the "simplest and least expensive thing" that patient access staff can do to improve patient satisfaction, says Weatherman.

"It is easy to want to stare into the computer while keying in data. But as questions are asked by the staff, they should use eye contact," he says. "We constantly remind our registrars about this."

• If you notice an employee giving good service, or are told they are providing this level of service by another access employee, send a handwritten thank-you note.

If Weatherman hears several compliments about a certain employee, he gives that individual movie tickets or a $10 gift card for a restaurant.

"We get a lot of mileage out of that," he says. "When we see something good happening, we say, 'Thank you for the way you handled that particular situation with a patient.'"

• Encourage staff to show genuine friendliness.

Recently, a registrar at Skaggs Regional Medical

EXECUTIVE SUMMARY

Your patient access staff can alleviate concerns of patients, whether due to lengthy waits in registration areas, clinical issues, or problems in other areas of the hospital.

- Instruct staff to make eye contact with patients.
- Offer meal vouchers if there are delays.
- Talk to managers of other departments if you learn of complaints.

Center in Branson, MO, gave a meal voucher to a woman who was waiting a long time for a test at an outpatient clinic.

"This type of effort costs little or nothing, but that patient will never forget our clinic," says Janet Deckard, inpatient financial counselor. "She most likely will recommend us to her friends."

Although the registrar can't give any clinical care to the patient, he or she can certainly provide emotional support, says Weatherman. "Smile when appropriate, and use common courtesy," he says. "Brief and appropriate small talk can definitely send a message to certain patients that they are not being herded through the process."

• **Provide scripting for everyday situations.** **Nicole Marsoobian,** supervisor of preregistration at Tufts Medical Center in Boston, says, "Over the last year, our ambulatory access trainer has done a great job at creating scripting and training material for the patient access team." *[The scripting used by patient access staff is included with the online version of this month's* Hospital Access Management. *"Go to http://www.ahcmedia.com/public/products/Hospital-Access-Management.html. On the right side of the page, select "Access your newsletters." You will need your subscriber number from your mailing label. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

The scripting covers answering the phone, handling difficult callers, sounding more professional, and using a better tone of voice. "I tell registrars to wait before speaking, avoid reacting to emotional customers, never interrupt, ask open-ended questions, and never reply with 'yes' or 'no,'" says Marsoobian. *(See a training exercise used by the department, left, and related stories on complaints involving other departments, below, and assessing customer service in registration areas, p. 67.)* ■

Try this to test listening skills

Below is a training exercise used by **Nicole Marsoobian,** supervisor of preregistration at Tufts Medical Center in Boston, to test the listening skills of her patient access staff:

Instructions: Have staff take out a pen and paper. Read the below exercise, and have them listen and write down what the caller in the exercise was speaking about. Read it fast!

Caller: "Hi, my name is Bob Smith. Last week, I was in the medical center for some tests that my doctor Krenshaw ordered. You told me that I didn't have to pay and you would bill my health insurance company. I have good insurance, OK, and now you want me to pay $500 and come back for more testing, and if I don't pay you are not going to give me service anymore. First, I never got a bill — again, my insurance is active, and another thing, community hospitals are supposed to just do what the doctor orders. Well, let me make something clear: You are the 100th person I spoke to today, and I am about ready to tell Dr. Krenshaw to send me somewhere else for this whatchamacallit test of his!"

Marsoobian then asks staff members to write down the answers to the following questions to test their listening skills:

- What is the patient's name?
- What is the doctor's name?
- What is the bill amount?
- How many bills has the patient received?
- Why is the patient upset? ■

'Unfair' complaints? Handle them anyway

Contact responsible departments

A patient's complaint that the TV didn't work in her room obviously had nothing to do with your patient access department. If a patient mentioned this to you, would you do anything about it?

"If I pick up on something like that, I will go to engineering and talk to them. **Keith Weatherman,** CAM, MHA, associate director of service excellence for the corporate revenue cycle at Wake Forest Baptist Health in Winston-Salem, NC. "Traditionally, a complaint like that could have been overlooked."

A patient might give a low score for a question involving registration on the organizationwide Press Ganey survey, when their dissatisfaction had nothing at all to do with patient access areas, acknowledges Weatherman. Even so, he says it's in your best interest to take responsibility for the complaint.

"When patients get these surveys, we can't sit there and walk through the survey with them. We just have to take what they say and interpret it," he says.

If Weatherman notices low satisfaction survey scores of certain clinics or ambulatory surgery areas, he goes to speak to the managers of those areas to find a solution. "They have their own registration folks, and they don't report to the revenue cycle, but we

need to get away from the mindset of finger-pointing," he says. "The complaint may not involve us, but I'm not satisfied with that. Even if it isn't our 'fault,' it's still our responsibility."

Excellent customer service by patient access staff can put patients at ease, even if they're already unhappy due to problems that occurred in other areas of the hospital, says **Amy Carr**, admitting supervisor for Monroe Carell Jr. Children's Hospital at Vanderbilt University Medical Center in Nashville, TN. "We can put a stop to dissatisfaction caused by other factors that we, admitting staff, have no control over," says Carr. "We let the patients know that they are our top priority."

Members of the patient access staff don't blame other areas for delays, Carr adds; instead, they convey the message that everyone is working together.

"We make sure we are 'elevating' our colleagues, instead of blaming others," she says. "This shows good teamwork and provides a sense of comfort for our patients." ■

Do you know how well you are doing?

Obtain feedback from patients, staff

Even though a hospitalwide satisfaction survey given to patients at Wake Forest Baptist Health in Winston-Salem, NC, was customized with wording such as "the person who asked you for your insurance information," patients still sometimes confuse their registration experience with other areas, says **Keith Weatherman**, CAM, MHA, associate director of service excellence for the corporate revenue cycle.

"When it comes to admissions, some patients lump everything else into it," he says. "We've tried surveying within particular registration departments. But after a while, we felt we were surveying our patients to death."

Patient satisfaction scores for patient access areas are compared with similar hospitals in the region, says Weatherman. On the last report, the ED registration area came in at the 74th percentile, and admissions came in at the 64th percentile, he says. "Our goal is to get to the 90th percentile, and maintain that," he says.

In addition to the hospitalwide survey, Weatherman talks to patients during rounding to assess the quality of service given by staff. If a patient complains about waiting, Weatherman finds out the reason for the wait and how long it will be. He then does something to make the patient more comfortable during the wait.

In conversing with a patient access employee while rounding, Weatherman learned that blankets used to be available from a certain department to offer patients, but they weren't offered any longer because the department moved.

"If she hadn't said something, I wouldn't have known about it," he says. "The very next day, laundry delivered a supply of blankets to admission."

Lobby is issue

Weatherman also discovered that the patients didn't like the open layout of the lobby, which was redesigned several years ago to be open and spacious.

"We have discovered that our lobby design doesn't work. The original thought was to make it a big, open airy place so it was not so institutional, but now we've backed off on that," he says. "Patients need to have a more private waiting area."

Patients felt they were "out on display" and occasionally became nauseated by the smell of food being brought through the area, he explains. When physician administrators visited admissions areas during hospitalwide rounds, they realized that patients didn't like the open lobby design. "That's how we were able to convince facilities planning to redesign it: because those folks saw it for themselves when they came through," he says.

The new design will separate registration areas from the main lobby, so that patients being registered or waiting for beds to become available can have a more private area.

"Registrars will be able to look out across the lobby and have more personal accessibility to the patients," he adds. "Patient access was heavily involved in this design, so if we are not happy with it, we only have ourselves to blame."

Patient access can't assume that hospital leaders know what the department needs, he says. "It's up to us to be the spokesperson and go to the folks above. They're not going to understand this unless we go to them," he says. "We need to do whatever it takes to be that squeaky wheel." ■

Save $4,500 yearly on paper costs

Departments save thousands in toner

Before a new electronic medical record system was implemented at Ochsner Health System in New Orleans, registrars made a minimum of five copies of

EXECUTIVE SUMMARY

By switching to a paperless system, patient access departments at Ochsner Health System saved $4500 a year in paper costs, and The University of Texas MD Anderson Cancer Center in Houston saved $9,000 in paper and toner costs in four years.
- Allow staff to access information on departmental appointments electronically.
- Link documents to the patient's record so these don't need to be printed.
- Enable registrars to locate documents required for claims processing electronically.

the patient's order, the face sheet, the appointment record, and patient label sheets. They sent all of these to clinical departments.

"We received two or three copies of faxed orders from the physicians or departments, per procedure," says **Tanya Powell**, patient access director for Ochsner's North Shore region.

After an electronic medical record system was implemented, paper costs were cut from $6,300 a year to $1,788, which resulted in more than $4,500 in savings for the patient access department, she reports.

The department is also saving money in toner costs and having less downtime due to non-working copy and fax machines, she says. "Time management and stress management are large, intangible metrics that are difficult to capture in dollars," says Powell.

Since patient access staff can access information on departmental appointments electronically, this access eliminates the "volumes of paper" required for each scheduled admission or procedure, says Powell. "Previously, registrars used 16 applications to execute a patient registration/admission. Now, we use one," she adds.

$9,000 is saved

The patient access department at The University of Texas MD Anderson Cancer Center in Houston saved $9,000 annually in combined paper and toner costs in four years after implementing a paperless system, reports **Bridgette Murray**, RN, MBA, CHAM, associate director of patient access services.

Murray says she's also seen "soft savings" because it's much easier for registrars to find documents required for claims processing. "There is increased patient satisfaction, related to fewer requests to produce the same document for multiple departments," she says.

Document sharing by pharmacy and patient billing services has improved workflow efficiency as well as increased patient satisfaction, adds Murray. "Patients that qualify for financial assistance were generally asked to produce similar documents by patient access and pharmacy for drug replacement programs related to income and residency," she notes.

Most of the documents that registrars normally would print are now electronically linked to the patient record, such as photo identification, insurance cards, authorization approvals, and online benefit verifications, she adds.

"Documents received via the fax server are linked by staff to the patient's record from their desktop," she says. "Any user with a business need for the document has access from their desktop." ■

Make your clinics allies to get auths

Obtain all required information

Until recently, an urgent care clinic continually sent patients to St. Nicholas Hospital in Sheboygan, WI, for radiology tests that weren't authorized, reports patient access manager **Robyn Rogers**.

"This was causing a great deal of conflict between the hospital and the clinic," she says. "As we weren't a continuation of an urgent or emergent visit, but rather, an outpatient hospital service, we needed to ensure that authorizations were in place before performing these tests."

Patient access leaders finally had a conference call with the clinic managers and agreed to allow the tests to be performed, if the clinic assured them that the authorizations always would be obtained. "We agreed to continue this practice, as long as we didn't receive any denials," says Rogers. "This was over a year ago, and it has been working quite well."

Although there wasn't a difference in the denial rate, the amount of work needed to follow up on authorizations decreased, with patient access staff spending much less time contacting insurance companies and physician's offices, says Rogers.

Patient access leaders recently arranged for the clinic to expand this practice to include tests ordered by

EXECUTIVE SUMMARY

By making clinics your partners in obtaining authorizations, claims denials can be dramatically reduced.
- Ensure that all required criteria are met.
- Educate schedulers on what clinical and referral notes are needed.
- Instruct all clinics to send information electronically instead of faxing.

physicians during scheduled office visits. "They were very happy to follow the same practice," says Rogers. "Patient access now has a much better relationship with the clinic."

Get required info

Authorization for elective services sometimes isn't obtained because there isn't enough time between the receipt of the reservation and the requested date of service, says **Marsha Kedigh**, RN, BS, MSM, director of admitting/ED registration/discharge station/insurance management at Vanderbilt University Medical Center in Nashville, TN.

"There may not be enough clinical notes in the patient record to support the admission, surgery, or procedure," she adds. "The fact that not all insurance companies have the same requirements for authorizations adds to the problem."

Some payers now require certain criteria to be met before an imaging procedure is ordered, such as the patient obtaining an X-ray before a CT scan is authorized, says Rogers. At Vanderbilt, the clinic is responsible for obtaining the pre-determination before insurance management staff can begin their pre-authorization, says Kedigh. "Providers may add CPT codes after the pre-authorization is obtained, or may change the patient's admission status during the pre-authorization process," she says.

Kedigh recommends keeping clinic schedulers and physicians informed on payer requirements for authorizations, such as clinical and referral notes.

"Educate them as to what is needed and when it is needed," says Kedigh. "Different payers have different guidelines for the content they need and for how long it will take to provide a response for authorization." *(See related stories, this page, on asking patients to sign insurance waivers, and steps to ensure authorizations are obtained.)* ■

Patient may refuse to sign insurance waiver

They won't be too happy

If a patient is scheduled for a high-dollar imaging procedure on short notice, this situation presents some additional challenges with obtaining authorizations, according to **Robyn Rogers**, a patient access manager at St. Nicholas Hospital in Sheboygan, WI.

"We experience the majority of our problems from patients that are scheduled for same-day or next-day services," she says. "This doesn't allow adequate time to ensure that the authorizations are in place for high-dollar imaging tests."

Often, patient access staff are unable to reach the patient prior to service to let them know that their test isn't authorized, adds Rogers. "This conversation may need to take place when the patient comes in for the test," she says. "At that time, without the authorization in place, they are then required to sign an insurance waiver."

Some patients have refused to sign the waiver, due to the high cost of these imaging procedures, and refused to have the test, says Rogers.

If a patient is having more than one procedure, the payer might authorize one procedure but not the other, or might deny authorization on the basis that a test is not medically necessary, says **Marsha Kedigh**, RN, BS, MSM, director of admitting, ED registration, discharge station, and insurance management at Vanderbilt University Medical Center in Nashville, TN.

Patients might be surprised to learn that a service isn't going to be covered by their insurance, and patient access staff will need to explain that insurance companies are revising their guidelines, says Kedigh. "Certain procedures that did not typically require authorization in the past now do require authorization," she says.

If the authorization hasn't been obtained close to the date of service, Vanderbilt's insurance management staff contacts the physician office to inform them of this situation.

"If we do not believe the authorization will be obtained, or the physician does not deem it as 'medically necessary,' the patient will then be asked to sign a waiver," Kedigh says. "If the patient refuses to sign, it is left up to the physician on whether he wants to proceed with the case or not." ■

Correct status of patient's admission

Prevent claim from being denied

An incorrect admission status on a patient can cause a delay in obtaining a required authorization, warns **Marsha Kedigh**, RN, BS, MSM, director of admitting, ED registration, discharge station, and insurance management at Vanderbilt University Medical Center in Nashville, TN.

For example, if a Medicare patient is going to have a procedure that is listed as "inpatient only" with Medicare, the admission status might be listed as "observation."

"Authorization staff now have to contact the clinic, to inform them the status has to change to 'inpatient' before they can process it," says Kedigh.

Likewise, an authorization might be obtained for outpatient status, but the physician writes an admit order, adds Kedigh. "This creates a denial, as the authorization was for the initial status of outpatient," she says. "You will need to revise the reservations form to be sure the correct terminology is used."

Vanderbilt's patient access department is reviewing all aspects of the reservation process, including clinics, insurance management, utilization management, and operating room scheduling, reports Kedigh. To prevent problems obtaining authorizations, she recommends these practices:

• Have all clinics use an electronic reservation form instead of paper faxes.

Paper faxes can be misplaced and can't be tracked, she explains. "A standard electronic form, used by all clinics, gives more guidance for what is needed at the front end of the reservation process," says Kedigh. "This streamlines the authorization process."

It is easier to hold staff accountable for their practice if all clinics process their reservations in the same manner, she says. "The expectation to obtain authorization in a timely manner increases when all the required elements are understood and in place when authorization begins," she says.

• Provide clinics with a list of needed items to obtain authorizations.

"So scheduling staff may refer to these when indicated," says Kedigh. "This ensures what is required on the initial submission of the reservation is present in the [electronic medical record]."

• Meet with clinic leadership to update them on issues that affect the authorization process.

"Give specific examples of cases from their clinic that created delays in obtaining the authorization," advises Kedigh. ■

Show new hires you expect much of them

Set high standards from the start

When **Roxana Newton**, CHAA, patient access supervisor at Porter Adventist Hospital in Denver, was interviewing a potential central scheduler, the applicant seemed taken aback by how many questions she was being asked.

"The interview process is vigorous, but it is to ensure the applicant understands what they are getting into," Newton says.

She explains to applicants that the information they collect from patients is "not only about time and place. It also concerns allergies and previous exams. There are serious medical questions that must be answered correctly to book an exam."

Newton always goes over the "big picture" of the patient access role with applicants, including receiving a call from the patient to book an exam, receiving a call about their benefits and the amount due at the time of service, and the patient arriving at the facility and checking in.

"I show the new hire that every piece is important, so they can see the patient care from every aspect," she says. "If the applicant reacts confidently that they could handle this workload, that is a sign that they will be a great addition to the team." Newton takes these steps to convey expectations to newly hired patient access employees:

• New hires receive computer-based and hands-on training.

"Once they are on their own, there is a three-month grace period for education," says Newton. "Following this probationary period, registrars are subject to corrective action if mistakes are made."

• New hires are made aware of the department's collection goals.

For example, emergency department registrars are expected to obtain at least 60% of all copays from patients covered by a commercial payer.

"We exclude Medicaid and Medicare, workers' comp, and auto insurances," says Newton. "With self-pays, we encourage a minimum of five dollars each. Those are counted toward their goal, but not against them, at this time, if they do not collect."

• New hires sign an acknowledgment form outlining their duties.

"We conduct monthly staff meetings and one-on one-meetings with each registrar," says Newton. "At the end of the day, there should never be a question as

EXECUTIVE SUMMARY

Patient access leaders must communicate to newly hired employees right from the beginning that expectations in the department are high. To set clear expectations for newly hired staff:

- Explain the department's collection goals.
- Ask employees to sign a form outlining their duties.
- Allow applicants to observe patient access staff at work.

to what is expected from them." *(See related stories on monitoring accuracy and doing "behaviorial" interviews, this page, questions to ask applicants, box on right, and helping new hires to succeed, p. 72.)* ■

Be clear: You expect accuracy

A registrar's position is very detail-oriented, and his or her ability to obtain accurate information is crucial for good patient care, says **Roxana Newton**, CHAA, patient access supervisor at Porter Adventist Hospital in Denver.

"It all begins in the hiring process. During interviews, it is relayed that we do hold staff accountable," she says. Newton tells new hires that they must be able to maintain accuracy while multi-tasking and must prioritize tasks in high-volume areas such as the emergency department.

Newton monitors every registrar's accuracy, including payer codes, guarantor information, patient demographics, and duplicate medical records or accounts created. "In total, we monitor 75 different errors that can occur," she says. "We hold staff to a 98% accuracy rate." Registrars run a "pre-bill edit report" every shift, which shows them any mistakes that were made.

"The errors can be fixed, so the bill can drop cleanly. They can correct the mistake before we count it against them," she says.

For example, if a certain payer's policy numbers all begin with a letter, and the payer code the registrar used started with a number, this number will show up as an error on the report.

"Denials have decreased by over half, by giving the registrar the ability to correct their own errors," says Newton.

Determine if applicants are well-fitted for job

When interviewing applicants for patient access positions at Children's National Medical Center in Silver Spring, MD, **Keisha Byam**, MPH, training manager and safety coach, asks detailed questions about the person's ability to adapt to change.

Byam's other questions focus on handling multiple tasks, setting priorities, being accountable, working as a team, and having positive interpersonal interactions. *(See box, this page, with some of the questions she asks.)* She also asks applicants to observe patient access employees at work.

"Candidates are provided with a real-life picture of job expectations, via watching other employees conduct daily activities," says Byam.

Here are other ways she ensures new hires do well:

• New hires sign an agreement.

Ambulatory services created a Standard of Employee Behavior form, which specifies expectations for attitude, communication, and commitment to co-workers. *[The form is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

"All employees sign this document, indicating

Ask applicants these questions

When **Keisha Byam**, MPH, training manager and safety coach at Children's National Medical Center in Silver Spring, MD, interviews applicants, she asks these questions:

- How many times in a six-month period were you tardy or absent unexpectedly?
- When your schedule or work is suddenly interrupted, what do you do?
- This job will require you to spend a large amount of time talking to people with difficult and sometimes upsetting circumstances. Can you give me three examples of when you had to work in this kind of situation and how you worked to resolve customer concerns?
- Tell me about a time in your work history when you were proud of your ability to be objective, even though you were emotionally upset about a situation.
- When have you found it necessary to use detailed checklists or procedures to reduce potential for error on the job? Be specific.
- Tell me about a time when you showed high enthusiasm and energy in order to create positive motivation in others. Give me a specific example. ■

COMING IN FUTURE MONTHS

- Offer same-day scheduling to patients
- Stop denials due to incorrect patient status
- Avoid pitfalls with switch to electronic system
- Ask your staff to identify problem applicants

awareness of the standards and a commitment to comply with each action step," says Byam.

• Realistic goals are set.

For example, it would be unfair to expect an employee to perform registrations in the emergency department or schedule follow-up appointments for patients if he or she didn't receive adequate training on these skills, says Byam.

• Inconsistent messages are avoided.

"Make sure it's the same message from the VP to the frontline," says Byam. "When employees hear different expectations, this leads to confusion in compliance." ■

New employees need aid to succeed

Loretta Buisson, director of patient access satellite facilities at Ochsner Health System in New Orleans, LA, looks for applicants who have great customer service skills, are highly motivated and dependable, and adapt well to change.

Buisson isn't the only one in the department who assesses the applicant's skills, however; patient access employees also give their input. "Not only does our manager interview the applicant, but we have department peer interview teams specific to the area in which the applicant will be working, such as the emergency department or patient registration," she says.

After an applicant is hired, Buisson takes these steps to help him or her succeed:

• The new hire is assigned a department mentor.

"The mentor is responsible for navigating the applicant through his or her work space and the functions of our department," says Buisson.

• At 30 days, the manager will meet with the new hire to discuss his or her progress.

• At 90 days, the manager conducts a progress evaluation, and again reviews expectations toward annual performance evaluation.

• Department-specific "information boards" are used to alert employees to successes and opportunities.

"We post our patient satisfaction scores, our monthly metrics report scores, and birthdays or employee announcements," says Buisson. ■

Tufts Medical Center

Front End Revenue Cycle Redesign

Registration Center Scripting Document

TUFTS MEDICAL CENTER STANDARD GREETING/CLOSING

Process/Action	Scripting
Greet the caller	*"Good Morning/Good Afternoon*
Thank the caller	*"Thank you for calling Tufts Medical Center."*
Identify department	*"Registration Center"*
Identify yourself	*"This is {your name}."*
Inquire	*"How may I help you?"*
When closing a call, you should always end with:	*"Is there anything else I can help you with?."*

Tips:

Listen to the caller to determine their needs. They may have been incorrectly routed to your extension and need assistance in getting connected to the correct area; they could be calling to ask a question about Tufts Medical Center in general. Actively listen, and do what you can to accommodate the caller. If they are an existing patient, we owe it to them to provide exceptional service, and want to keep them as our patients. If they are not currently a patient, we want them to choose Tufts Medical Center for their healthcare needs. We want to be referred by others, not only for the outstanding medical care that our clinicians provide, but also for our reputation in providing a pleasant and helpful experience to our patients.

TRANSFERRED TO REG CENTER BY CLINIC FOR NEW/UPDATED REGISTRATION

Process/Action	Scripting
Greet the caller	*"Good Morning/Good Afternoon*
Thank the caller	*"Thank you for calling Tufts Medical Center."*
Identify department	*"Registration Center"*
Identify yourself	*"This is {your name}."*
Inquire	*"How may I help you?"*

Clinic patient service coordinator should give brief description of what is needed and provide patient name and MRN. You should pull up the patient record and proceed with registration.

Process/Action	Scripting
Greet the caller	*"Good Morning Mr./Ms. {patient name}. I will need to ask you some questions to complete registration; it should only take a few minutes".*
Verify Minimum demographics	**"***Just to be sure I pulled up the correct patient record, can you please provide your current address and the best phone number to reach you at during the day?"*

Process/Action	Scripting	Comment
Guarantor Rel to Pt	*"Who would be responsible for any outstanding balances on the account? We refer to this as the guarantor."* **If the response is not the patient, follow with:** *And what is the relationship to the patient?*	Enter the guarantor's relation to the patient. If the patient is an adult enter S for self. All the patient data will default onto the guarantor screen. If the patient is under 18, use the help screen (PF24) to select the appropriate value.
Guarantor First Name	**If set to S (self), name will default, otherwise:** *"Can you please spell the guarantor's first name?"*	

Guarantor Last Name	**If set to S, M, F or 2, name will default, otherwise:** *"And…the guarantor's last name?"*	If the relation selected in the Rel to Pt field is a family member i.e. mother, father etc, the last name will default from the patient. If it is not a family member, enter the guarantor's last name.
Guarantor Address	**If set to S, M, F or 2, name will default, otherwise:** *"Can you please provide a current mailing address?"*	If the relation selected in the Rel to Pt field is a family member, the address will default from the patient's address. If it is not a family member enter the guarantor's address.
Guarantor Home Phone	**If set to S, M, F or 2, name will default, otherwise:** *"And…a home telephone number?"*	If the relation selected in the Rel to Pt field is a family member, the home phone will default from the patient's home phone. If it is not a family member enter the guarantor's home phone.
Guarantor Day Phone	**If set to S, M, F or 2, name will default, otherwise:** *"What is the best number to reach {guarantor name} at during the day?*	

Process/Action	Scripting	Comment
Guarantor Employer Name	*"Can you provide the name of your {guarantor name } employer?"*	Enter the name of the guarantor's employer.
Guarantor Employer Address	**"***And… the address including zip code?"*	Enter the employer's address.
Guarantor Employer Phone	**"***Great, thanks. And how about the employer phone number?"*	Enter the guarantor's employer phone number.
Emergency Contact Rel to Pt	*"Who would you like to designate as an emergency contact and what is the relationship to you/the patient?*	Enter the primary emergency contact's relation to the patient. *Note: The primary contact information is required.

TRANSFERRED TO REG CENTER BY CLINIC FOR NEW/UPDATED REGISTRATION

Emergency Contact First Name	*Can you please spell the Emergency contact's first name?"*	Enter emergency contact's first name.
Emergency Contact Last Name	*"And…the Emergency Contact's last name?"*	If the relation selected in the Rel to Pt field is a family member i.e. mother, father etc, the last name will default from the patient. If it is not a family member, enter the emergency contact's last name.
Emergency Contact Address	*"Can you please provide a current mailing address?"*	If the relation selected in the Rel to Pt field is a family member, the address will default from the patient's address. If it is not a family member enter the emergency contact's address.
Emergency Contact Home Phone	*"And…a home telephone number?"*	Enter the emergency contact's home phone number.
Emergency Contact Day Phone	*"What is the best number to reach {emergency contact name} during the day?*	Enter the emergency contact's day phone number.
Insurance Verification	*"Ok, at this point, I'll need to verify your insurance eligibility. What is your current insurance carrier and policy number?"* **After verifying primary insurance, you would need to ask the patient:** *"Do you have any additional insurance coverage?"* **If secondary insurance, follow with:**"*Which insurance plan would we bill first?"*	Enter the appropriate COB Priority (is this the patients' primary or secondary insurance plan?)
If coverage is not active or not found	*"According to {patient insurance plan}, your coverage is not currently active. I am going to need to connect you to Financial Coordination for further assistance, do you mind holding while I get them on the line? (wait for response)."*	Warm transfer to financial coordination at ext. 6013.
Subscriber information	***"****Are you the subscriber for this insurance?"* **If response is no, follow with:** *"Who is the subscriber for this plan, and how are they related to you (or patient)?*	Enter the subscriber's relationship to the patient. If the patient is the subscriber all other fields will default from patient information. If the patient is not the subscriber, it may be necessary to submit an eligibility

		request for the subscriber using the policy number to obtain the subscriber's date of birth.
Subscriber employment/military information	*"What is the subscriber's employment status?* **If employed: "***Ok, and what is the name of the employer"* **If military: "***Ok, and where is {subscriber name} stationed?"*	Enter the subscriber's employment/military status and name of employer or military station.
Complete Registration/Patient reminders	*"Ok Mr./Ms {patient last name}, your registration has been completed. We will be sending you a registration card that you will need to bring with you to your appointment. Please remember to bring your insurance card and co-payment as well.* **If PCP is not a Tufts Physician, follow with***: Also if your insurance company requires a referral for medical visits outside of your primary care, you'll need to contact your primary care doctor to obtain a referral. The referral can be faxed to 617-636-1046. If you do not obtain a required referral, your insurance company could deny coverage for this appointment, and you would be responsible for full payment.* ***Closing:** Is there anything else I can help you with today? I have time."*	

Eventually, patients may call the registration center before getting transferred to the clinic for scheduling. Only when you've determined that the caller is looking to schedule an appointment and needs to be registered would you proceed with the following:

Process/Action	Scripting	Comment
Establish if new or existing	*"Have you been to Tufts Medical Center before?"*	Wait for a response, however, no matter what the answer is, you'll need to perform an inquiry before the system will allow you to create a new medical record number (MRN). This control was put in place to avoid creating duplicate MRNs since some callers were treated here as children and don't remember.
If the caller's response is yes, follow with:	*"Do you happen to have your medical record number available? If you have a blue or red card with our hospital logo on it, that card will indicate the number I'm looking for."*	If they have the number, you can perform a numeric search using the MRN number to pull up the patient record for scheduling.
If the caller's response is no or if the caller does not know their MRN, follow with:	*"Ok, no problem. Let me see if I can find anything in our system. May I please have the correct spelling of your last name?"*	Be sure that you are asking for the correct spelling of their last name, do not make assumptions as it's very important to have accurate data. **Note:** Do not use periods, commas or apostrophes when entering the last name. For hyphenated names, do not enter spaces before or after the hyphen.
Obtaining accurate first name	*"And…the correct spelling of your legal first name?"*	You will need to ensure that the name in our system is their legal name (i.e. Robert vs. Bob).
At this point, you should be able to input the patient's sex based on the name; however, if it's unclear, you should do a search on both M and F with the patient's name.	*N/A*	N/A
If your search was unsuccessful, you will be required to do a phonetic inquiry before the system will allow you to add the individual as a new patient. If your search was successful, you'll want to verify the information that appears on the screen by saying the following:	*"Our system performed a search on your name and came up with an existing medical record number. Have you ever lived at {address displayed}?"*	If the caller's response is yes you'll need to verify the information in the system and obtain any changes. If the response to the above question is no, or if the search was unsuccessful you will need to add them into the system as a new patient.

NEW PATIENT – NO MRN

If determined that you need to add caller as a new patient you will need to ask the following:

Process/Action	Scripting	Comment
DOB	*What is your date of birth Mr./Ms {patient last name}?*	
Address	*What is your current mailing address?*	City and State will default when you enter zip.
Zip	*And…your zip code?*	
Marital Status	*What is you marital status?*	
Home Phone	*What is your home telephone number?*	
Day phone	*What is the best number to reach you during the day?*	
Race	*What is your race?* **If patient is hesitant or questioning the need for this information, follow with:** *"This is a Boston Health Commission requirement for statistical purposes."*	If patient refuses, choose unknown.
Ethnicity	*What is your ethnicity?* **If patient is hesitant or questioning the need for this information, follow with:** *"This is a Boston Health Commission requirement for statistical purposes."*	If patient refuses, choose unknown.

Process/Action	Scripting	Comment
Guarantor Rel to Pt	*"Who would be responsible for any outstanding balances on the account? We refer to this as the guarantor."* **If the response is not the patient, follow with:** *And what is the relationship to the patient?*	Enter the guarantor's relation to the patient. If the patient is an adult enter S for self. All the patient data will default onto the guarantor screen. If the patient is under 18, use the help screen (PF24) to select the appropriate value.
Guarantor First Name	**If set to S (self), name will default, otherwise:** *"Can you please spell the guarantor's first name?"*	Enter guarantor first name if not self.
Guarantor Last Name	**If set to S, M, F or 2, name will default, otherwise:** *"And…the guarantor's last name?"*	If the relation selected in the Rel to Pt field is a family member i.e. mother, father etc, the last name will default from the patient. If it is not a family member, enter the guarantor's last name.
Guarantor Address	**If set to S, M, F or 2, name will default, otherwise:** *"Can you please provide a current mailing address?"*	If the relation selected in the Rel to Pt field is a family member, the address will default from the patient's address. If it is not a family member enter the guarantor's address.
Guarantor Home Phone	**If set to S, M, F or 2, name will default, otherwise:** *"And…a home telephone number?"*	If the relation selected in the Rel to Pt field is a family member, the home phone will default from the patient's home phone. If it is not a family member enter the guarantor's home phone.
Guarantor Day Phone	**If set to S, M, F or 2, name will default, otherwise:** *"What is the best number to reach {guarantor name} at during the day?*	Enter the guarantor's day phone.
Guarantor Employer Name	*"Can you provide the name of your {guarantor name } employer?"*	Enter the name of the guarantor's employer.
Guarantor Employer Address	**"***And… the address including zip code?"*	Enter the employer's address.
Guarantor Employer Phone	**"***Great, thanks. And how about the employer phone number?"*	Enter the guarantor's employer phone number.
Emergency Contact Rel to Pt	*"Who would you like to designate as an emergency contact and what is the relationship to you/the patient?*	Enter the primary emergency contact's relation to the patient. *Note: The primary contact information is required.
Emergency Contact First Name	*Can you please spell the Emergency Contact's first name?"*	Enter emergency contact's first name.

Emergency Contact Last Name	*"And…the Emergency Contact's last name?"*	If the relation selected in the Rel to Pt field is a family member i.e. mother, father etc, the last name will default from the patient. If it is not a family member, enter the emergency contact's last name.
Emergency Contact Address	*"Can you please provide a current mailing address?"*	If the relation selected in the Rel to Pt field is a family member, the address will default from the patient's address. If it is not a family member enter the emergency contact's address.
Emergency Contact Home Phone	*"And…a home telephone number?"*	Enter the emergency contact's home phone number.
Emergency Contact Day Phone	*"What is the best number to reach {emergency contact name} during the day?*	Enter the emergency contact's day phone number.
Insurance Verification	*"Ok, at this point, I'll need to verify your insurance eligibility. What is your current insurance carrier and policy number?"* **After verifying primary insurance, you would need to ask the patient:** *"Do you have any additional insurance coverage?"* **If secondary insurance, follow with:**"*Which insurance plan would we bill first?"*	Enter the appropriate COB Priority (is this the patients' primary or secondary insurance plan?)
If coverage is not active or not found	*"According to {patient insurance plan}, your coverage is not currently active. I am going to need to connect you to Financial Coordination for further assistance, do you mind holding while I get them on the line? (wait for response)."*	Warm Transfer to Financial Coordination ext. 6013
Subscriber information	**"***Are you the subscriber for this insurance?"* **If response is no, follow with:** *"Who is the subscriber for this plan, and how are they related to you (or patient)?*	Enter the subscriber's relationship to the patient. If the patient is the subscriber all other fields will default from patient information. If the patient is not the subscriber, it may be necessary to submit an eligibility request for the subscriber using the policy number to obtain the subscriber's date of birth.

Subscriber employment/military information	*"What is the subscriber's employment status?* **If employed: "***Ok, and what is the name of the employer"* **If military: "***Ok, and where is {subscriber name} stationed?"*	Enter the subscriber's employment/military status and name of employer or military station.
Complete Registration/Patient reminders	*"Ok Mr./Ms {patient last name}, your registration has been completed. Your medical record number is {MRN generate}. Please take note of this number, as you may need to use this again for future appointments. We will be sending you a registration card that you will need to bring to your appointment. I can now connect you to the clinic for scheduling of your appointment. Do you mind holding while I connect you to {CLINIC}, that way I can let them know that you have completed registration, and provide them with your medical record number.* **(Wait for response). If patient says they do not mind, follow with:** *"Great, and if for some reason the call gets disconnected, you can contact the {CLINIC} directly at {CLINIC phone number}. Also, remember to bring your insurance card and co-payment with you to your appointment.* **If PCP is not a Tufts Physician, follow with:** *Also if your insurance company requires a referral for medical visits outside of your primary care, you'll need to contact your primary care doctor to obtain a referral. The referral can be faxed to 617-636-1046. If you do not obtain a required referral, your insurance company could deny coverage for this appointment, and you would be responsible for full payment.* ***Closing:*** *Is there anything else I can help you with today? I have time."*	

WARM TRANSFER PATIENT TO CLINIC FOR SCHEDULING

Process/Action	Scripting
To Patient	*"Mr./Ms. {patient name}, do you mind holding while I connect to the clinic? (*Wait for response) "*Ok, thank you for completing registration, and have a great day."*
To Patient Service Coordinator in Clinic	*Good Morning/Afternoon {Clinic staff's name}, this is {your name} from the Registration Center, and I have Mr./Ms. {patient name} on the line who needs to schedule a new patient appointment. They have completed registration and their MRN is {patient MRN}. Is there anything else you need?*

WARM TRANSFER PATIENT TO FINANCIAL COUNSELING

You would warm transfer the patient to financial coordination at ext. 6013 for the following scenarios:

- You've attempted to verify insurance and have found that the patient is inactive/not currently covered
- The patient has indicated that they are self-pay
- The patient indicates they have Celtic Care insurance

Process/Action	Scripting
To Patient	*"Mr./Ms. {Patient last name}, I am going to need to connect you to Financial Coordination for further assistance, do you mind holding while I get them on the line? (wait for response)."*
To Financial Coordinator	*"Good afternoon {financial coordinator name}, this is {your name} and I have Mr./Ms. {patient last name} on the line who has an appointment scheduled for {appointment date}, however {they do not currently have active insurance/we were unable to verify insurance}. Their MRN is {patient MRN}. Is there anything else you need?*
To Patient	*"Ok Mr./Ms. {patient last name}, thank you for calling Tufts Medical Center. {Financial coordinator name} will assist you from here."*

Source: Alyson Landry, Manager of Ambulatory Access and Training, Tufts Medical Center, Boston.

Ambulatory Services:
Standards for Employee Behavior

A set of performance standards have been developed to establish specific behaviors that all employees are expected to practice while on duty.

By incorporating these standards as a measure of overall performance, Ambulatory Services makes it clear that all employees are expected to adhere to and practice the Standards for Employee Behavior.

Attitude

- Our job is to serve our customers and provide high quality service with care and courtesy.
- Acknowledge a customer's presence immediately. Smile and introduce yourself at once.
- Take extra steps to make customers comfortable.
- Address the customers need directly or identify and contact someone who can.
- Always thank customers for choosing Children's National.

Appearance

- Be clean, neat, tidy and well groomed.
- Follow dress code policies and wear your identification badge correctly at all times.
- Pick up litter and dispose of it properly.
- Clean up spills and return equipment to its proper place.
- Keep your work space neat, organized and free of confidential patient information.

Communication

- Listen to customers. Be courteous. Don't use jargon.
- Use Please, Thank you and Welcome in an appropriate manner.
- When someone needs directions, escort that person to his or her destination.
- Know how to operate the telephones and pagers in your area.
- Answer calls within three rings. Identify your department and yourself and ask, "How may I help you?"
- Provide the correct number before transferring a call. Get the caller's permission before putting him or her on hold and thank the caller for holding.
- Identify yourself and phone number when text paging.
- Prepare the customer for their appointment experience by informing them of appointment specifics, insurance requirements, and important information.

Commitment to Co-workers

- Treat one another as professionals deserving courtesy, honesty and respect. Welcome newcomers and present yourself as a resource for learning.
- Offer to help fellow employees whenever possible.
- Cooperate with one another. Don't undermine other people's work; praise whenever possible. The team functions best when everyone performs their role.
- Do not embarrass fellow employees in the presence of others.
- Address problems by going to the appropriate supervisor.

SOURCE: Developed by Children's National Medical Center, Silver Spring, MD, based on material from the Studer Group.

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Customer Waiting

- Check frequently to make sure everyone's needs are being met.
- Alert clinicians to patients waiting.
- Educate families about processes and provide a comfortable atmosphere for waiting customers.
- Offer an apology if a wait occurs. Assist customers who need to reschedule. Always thank customers for waiting.

Elevator Etiquette

- Always smile and speak with fellow passengers; hold the door open for others.
- Pause before entering an elevator so you do not block anyone's exit. Step aside or to the back to make room for others.
- When transporting patients in wheelchairs, always face them toward the door and exit with care.

Engagement

- Always be attentive, helpful and empathetic to the needs of our patients and families.
- You are responsible for your actions at all times.

Privacy

- Make sure that patient information is kept confidential. Never discuss patients and their care in public areas.
- Knock before entering a room. Closes curtains or doors during exams and procedures.
- Refrain from accessing information (registration, scheduling) not related to current job function.

Safety Awareness

- Report all accidents or incidents promptly.
- Correct or report any safety hazard you see.
- Practice Safety Behaviors at all times (SBAR, Handoff, Coaching)
- Use protective clothing, gear and procedures when appropriate.

Sense of Ownership

- Look beyond your assigned tasks and assist others when necessary.
- Always look for answers and refrain from saying "I Don't Know."
- Take pride in this organization as if you own it. Accept the responsibilities of your job.
- Adhere to policies and procedures. Live the values of this organization. Do the right thing.

I have read and understand the Standards for Employee Behavior, and I agree to comply with and practice the standards outlined above.

_____ _____

Print Name Signature of Applicant & Date

SOURCE: Developed by Children's National Medical Center, Silver Spring, MD, based on material from the Studer Group.

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