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January 2013: Vol. 32, No. 1
Pages 1-12

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During hurricane, 'no such thing as titles' in patient access areas

Managers worked hard to maintain morale

Patient access employees arrived for work before Hurricane Sandy in October knowing that their shift could last for 24 hours or more, reports **Linda Radcliffe**, CHAM, manager of patient business services at Virtua Berlin, a hospital in Berlin, NJ.

"As the storm raged, power in the towns surrounding us was out, and it seemed like complete darkness all around. The uncertainty we were facing was scary," says Radcliffe. "Looking out of the emergency room doors, all you could see was driving rain and darkness. It was a very eerie feeling."

Pattie Froehling, director of the revenue cycle at North Shore Health System in Manhasset, NY, says that in a crisis such as Sandy, "there are no titles at that point. Everybody rolls up their sleeves, chips in, and does what they need to do."

In patient access areas at New Brunswick, NJ-based Robert Wood Johnson University Hospital, "everyone — managers, supervisor, directors, assistant directors, and registrars — joined in and helped. This boosted the staff's morale tremendously," says **Lazara Richardson**, ED registration manager.

According to **Joan Braveman**, corporate director patient access of Lourdes Health System in Camden, NJ, "during a crisis, having a manager work side by side with you has more meaning than anything else you can do."

Here are some challenges patient access leaders faced during Hurricane

EXECUTIVE SUMMARY

Patient access leaders report maintaining morale, coping with anxious employees, and moving registrars to assist in the emergency department were their top challenges during Hurricane Sandy.

- Managers worked alongside frontline staff.
- Managers allowed staff to use cell phones and personal email to reach their families.
- Managers placed registrars who had never worked in the emergency department in the quick care area alongside colleagues.

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Sandy:

• Registrars already at the hospital couldn't make it home, and others couldn't make it in.

At North Shore Health System's hospitals, some registrars stayed overnight and slept on blow-up mattresses. "For our registration staff, there is an expectation that you need to be there. It's just part of the nature of the job that they have," Froehling says. "They are putting their families on the backburner to make sure patients get what they need."

Some registrars who didn't make it in during the storm managed to report for work the next day despite lack of power, no public transportation, and downed power lines, adds Froehling. To maintain morale for registrars who worked through the storm, Froehling gave "continuous positive feedback. Staff were fearful for their families as well."

As the storm worsened, registrars asked if they could leave, although many were ready to spend the night if necessary, says Shelley Edwards, CHAA, patient access manager at Lourdes. Once it was determined that other departments had adequate staffing, registrars who lived furthest away were allowed to leave first.

"There was a lot of anxiety over, 'Am I going to be able to get back home?'" says Edwards, who made staffing decisions based in part on updates given by the hospital's disaster planning department, which covered road closures, downed power lines, and areas of power loss.

Braveman says, "Those updates were really helpful. It looked like there was going to be a lull in the storm, so we sent staff home at that time. We then asked the night shift to come in early."

Some of the members of Virtua's patient access staff stayed through the night. They took turns working, and then tried to catch some sleep napping on cots or wherever they could find some quiet space. "The second shift on Monday came in early so the morning staff could rest," says Radcliffe. "The Monday night shift was canceled, as was the first shift on Tuesday, so that colleagues would not have to venture out in the worst storm of our lifetime." Mostly ambulance patients were admitted during those shifts, which were staffed by the day shift employees who stayed over to work.

• Patient access staff had to register transferred patients from evacuated facilities.

"The number one thing was making sure they are comfortable, and communication to ease the patient's mind that the family was contacted and knew where they were," Braveman says. "We made sure all the demographic information was correct so we could contact family members."

• Patient access staff had to notify patients about canceled appointments.

Once the decision to cancel all elective surgeries the following day was made at Lourdes, the patient access team immediately started calling patients to alert them, as well as patients scheduled for preoperative testing.

"Only one person showed up, out of hundreds that we schedule each day, and we did service recovery for him," says Edwards.

At the same time, registrars fielded dozens of calls from patients and family members who wanted to know if their appointment was canceled. "It was a tremendous amount of phone calls. We took some of the burden off of the outpatient diagnostic departments and surgery," says Edwards.

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

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Registrars gave patients the central scheduling number to reschedule their appointments, because they couldn't connect them to that number at the time. "We identified that as an area that we really did not have a good backup plan for," Braveman says. "Unfortunately, the phone system in that building went down, and patients weren't able to even leave messages."

• Managers set up charging stations for cell phones and computers, which allowed staff members access to their personal email or social media sites.

Annemarie Rappleyea, CPAR, patient access supervisor for the emergency department at Community Medical Center in Toms River, NJ, allowed her staff to make numerous calls to get through to their families. Several returned to working with their mind at ease after learning their family had safely relocated.

• Managers did hourly rounds with staff to address personal issues.

Patient access managers at Community Medical Center normally round with staff weekly to update them on department issues, but these rounds were mostly focused on staff's own needs. One registrar needed to leave to relocate her family, and another registrar with small children was provided with gas for the family's generator.

"A lot of staff were worried about their own families. We and asked them if there was anything they needed at home that we could assist with," says Rappleyea. "We told them they were doing a tremendous job." *(See story on how departments handled surges in ED volume, right, and ways to thank staff, p. 4.)*

SOURCES

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Access staff coped with ED volumes

Staffing shortages and having to pull staff from other areas due to volume surges in the emergency department (ED) were two challenges **Annemarie Rappleyea,** CPAR, patient access supervisor for the ED at Community Medical Center in Toms River, NJ, faced during Hurricane Sandy.

"The outpatient department and financial counselors were pulled to the ED to assist, in order to replace employees who weren't able to make it in," she says.

The ED saw a sudden surge in volume, including individuals unable to get their medications due to pharmacies being closed or who ran out of oxygen due to power shortages, as well as those with storm-related injuries.

Rappleyea staffed the ED's quick care area with one experienced ED registrar alongside the outpatient and financial counselors who were pulled from other areas. With this system, staff who had never worked in the ED before didn't have to suddenly adjust to the crowded, chaotic main ED.

It also helped that all of the hospital's registration areas use the same software. "So it was just a matter of getting them acclimated to the department," says Rappleyea. "When we pulled the staff to the ED, we assigned them to their own group in one area, with their coworkers. We moved the actual ED staff throughout the department."

The EDs at Camden, NJ-based Lourdes Health System saw a significant number of homeless individuals who mistakenly thought that shelters were being set up only for people whose housing was damaged by the storm, says Joan Braveman, corporate director, patient access. "There was no public transportation, and when they were found not to be ill, our challenge was to get them back to the shelter," says Braveman, adding that some registrars volunteered to drive individuals to ease the burden on the ED.

At Robert Wood Johnson University Hospital in New Brunswick, NJ, the storm resulted in a surge of patients presenting to the ED for several days, reports ED registration manager **Lazara Richardson**. EDs throughout the region were also caring for patients in need of medical shelter, Richardson adds. "Needing medical attention that became unavailable during the storm and its aftermath, these patients came to the hospital for care and assistance," she says. They included dialysis patients, mechanically-vented patients, and patients on continuous oxygen.

"We also saw many elderly 'social admits,' and

patients too frail to stay at home without heat or electricity," says Richardson.

Kathy B. MacGillivray, MHA, director of access management services at Robert Wood Johnson University Hospital, says that when hospital administration opted to cancel elective admissions because of the storm, "we pooled all of our personnel resources to focus on addressing the ED volume. We were able to do this only because we maintain cross-training standards."

Inpatient registration teams were dispatched to the ED to support the volume surge in that area. "Practices that maintain staff competencies in all registration pathways and area-specific requirements made the reassignment possible," MacGillivray explains. ■

Say thank you after a crisis

Here are some ways that patient access managers showed registrars their appreciation after Hurricane Sandy:

• Shelley Edwards hand-wrote thank you notes to every person who came in during the storm. Edwards thanked them for coming in and also gave each of those staff members a card to exchange for $5 at the gift shop or a free meal in the cafeteria.

• Some staff tried to make it in and were stopped by road closures, so Edwards called each one to be sure they arrived home safely.

• Patient access leaders at Robert Wood Johnson University Hospital in New Brunswick, NJ, provided staff with a homemade breakfast one morning and a pizza party another day.

"A member of the management team acted as 'house mother' and made breakfast to order," says **Kathy B. MacGillivray**, MHA, director of access management services. "Staff was absolutely appreciative, as many staffers themselves were still without power at home. So a hot meal was a special treat." ■

New process makes providers happier

Problems fixed before patients arrive

Before a centralized pre-registration department was created at Cambridge (MA) Health Alliance, patients sometimes received unpleasant, unexpected news when they arrived for a scheduled appointment — not about their medical condition, but their insurance coverage.

"In the past, the patient could be evaluated by a provider and receive laboratory tests or X-rays during the visit. After the visit, the claim billed to the insurance company would deny due to seemingly avoidable problems," says **Bettye Sabree**, MHA, director of pre-registration and centralized referrals.

In some cases, the visit was denied because the patient's insurance information was listed incorrectly or the patient did not have the correct primary care provider listed. In other cases, there was no referral in place from the patient's primary care provider. *(See related stories on how patient access staff members were trained in the hospital's new preregistration process, p. 5, and ensuring the correct primary care provider is identified, p. 6.)*

"Tensions can arise, with everyone blaming each other for incorrect insurance, subscriber, or demographic information," says Sabree. To address this problem, patients who call scheduling are now transferred to a centralized preregistration department if they meet any of these criteria:

• self-pay patients;

• patients insured by a plan not contracted with Cambridge Health Alliance;

• new patients;

• patients assigned to a primary care provider outside Cambridge Health Alliance;

• patients whose last pre-registration date is more than 45 days;

• patients injured in an industrial or motor vehicle accident.

If one of the criteria is met, a pop-up in the electronic scheduling system appears and notifies the scheduler to transfer the call to the pre-registration department before confirming the appointment.

EXECUTIVE SUMMARY

Patients have fewer unexpected delays when checking in for scheduled appointments due to a new preregistration process implemented at Cambridge Health Alliance.

• Patients who call to schedule an appointment and meet defined criteria are given the option of speaking with a centralized pre-registration department.

• Patients are given the option to call back at a convenient time.

• Patients are assisted with the process of selecting a primary care provider as required by their managed care health insurance.

"This gives us an opportunity to identify any issues with their insurance before the patient comes in for their appointment," says **Sylvia C. Motta**, manager of pre-registration and the call center. "When the patient does present on the appointment day, the patient simply checks in, rather than go through the whole registration process."

Previously, scheduled appointments sometimes were delayed when patients checked in, and the registration process took some time to complete. "This dissatisfied patients, and it also caused a disruption in the provider's schedule," says Motta. "This new system strives to makes sure those issues rarely happen."

Motta has found that most patients prefer to give their demographic information over the phone. "It is more secure and private, compared with providing this information in a lobby with people in line behind them," she explains. "Patients also appreciate that when they arrive at other departments, their information is already updated. They don't have to repeat the process."

Communication breakdowns

Occasional breakdowns in communication still occur at times with the new process, says Sabree. After calls were transferred, some patients expressed annoyance due to the length of time it took to confirm their demographic and insurance information.

"We found out it was beneficial to let patients know how long the process would take at the beginning of the call," Sabree says. "We simply tell them, 'This process is going to take eight to 10 minutes to verify your demographic and insurance information. Do you have 10 minutes to spend to pre-register?' If the answer is 'no,' we ask them to call back at their convenience, as the department is open until 8 p.m. Monday through Thursday and until 5 p.m. Fridays," she says.

If the scheduler doesn't transfer the call to pre-registration or the patient hangs up, it becomes a "blame game," says Sabree. "Preregistration staff says the call wasn't transferred, and departments complain that the preregistration department didn't update the patient's information. This is improving."

SOURCES

For more information on implementing a pre-registration program, contact:

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'Massive' training before new process

Every patient access employee at Cambridge (MA) Health Alliance (CHA) participated in a "massive" training program provided by the organization's training, customer service, and information technology departments before a new preregistration program was rolled out, says **Bettye Sabree**, MHA, director of pre-registration and centralized referrals.

Staff members were given step-by-step instructions on the new process and the updated electronic scheduling system functionality. Staff were asked to use specific scripts, so that everyone within the organization communicated the same message to patients. *[The scripts are 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.]* Ongoing education keeps staff apprised of changes in payer requirements.

"You really cannot over-communicate," says Sabree.

Patient access leaders communicate these changes to employees via the department's newsletter, but they give managers the information first at monthly meetings. **Sylvia C. Motta**, manager of pre-registration and the call center, says, "If they have any questions, we can address those at that time and make adjustments before it's in the newsletter."

One issue involved the way newborns were preregistered. "Through a couple of meetings with department managers and the pre-registration department, a new process was created that eliminated the concerns department managers had concerning updating newborn information," says Motta.

The existing process made it difficult for departments to match lab work to the patient, she explains. The lab work done when the child was born was completed under "babyboy Smith" or "babygirl Smith," which was updated to an actual name by pre-registration staff. "The new process is that if the child is born at CHA, pre-registration leaves the name as "babyboy/girl Smith," and the department updates it to an actual name when the baby arrives at the clinic," says Motta. "On the other hand, if the child is born outside of CHA, then pre-registration updates it to the real name." ■

Wrong PCP? Correct information before arrival

Lack of referral is issue

Before a pre-registration department was created at the organization, insurance requirements for patients to identify a primary care provider used to result in delays in scheduled procedures fairly often, until a pre-registration department was created, says **Bettye Sabree**, MHA, director of pre-registration and centralized referrals at Cambridge Health Alliance in Medford, MA. "When the patient came in and we checked eligibility, in a lot of cases, the patient did not know that the doctor they were coming in to see was not the doctor listed with their insurance company," she explains.

This situation meant that patients covered by commercial insurance were asked to sign a waiver and leave a visit deposit instead of just a copay, and they would end up receiving a bill, says **Sylvia C. Motta**, manager of pre-registration and the call center.

Even if the patient was willing to take the time to update the information on the spot, it took up to 20 minutes to complete, which disrupted the provider's schedule. "Now, staff take care of this before the patient comes in," says Sabree. "They establish a three-way conversation on the phone between the patient and themselves and the insurance company. They work with the patient to select a primary care provider, if that's what the patient wishes to do."

The new system addressed the number one concern of providers: to keep their schedule going smoothly. "The flow has to be continuous, especially for providers offering same-day access," says Motta. "One delay like this about insurance issues can throw their whole schedule off."

Previously, providers were unable to refer the patient for specialty care, as technically they couldn't give a referral to a patient who wasn't theirs. If the provider wanted to take the patient to surgery, for example, they would find they could not, because the required authorization wasn't in place.

"If there is no referral in place with the primary care physician, that provider encounters delays trying to schedule that procedure for the patient," says Sabree. "But if everything is aligned prior to check in, it all goes smoothly."

The electronic scheduling system has been programmed to capture the names of patients who have been scheduled with appointments and meeting preregistration criteria, which appear on a Pre-Registration Department worklist. These patients will receive a preregistration telephone call from the department. If the Preregistration Department doesn't speak with the patient directly, for any reason, their insurance is still confirmed electronically using insurance company verification systems and staff notes are entered beside the patient's name on the appointment schedule to indicate what is needed.

"Examples of messages include 'Primary care provider update needed with insurance company,' 'Verify the patient's date of birth,' or 'Obtain subscriber information,'" says Sabree. "When the patient checks in, the front desk can clearly see what is needed." ■

Does patient need interpreter services?

Identify need early in the process

If patients are financially cleared and pre-registered before they present for services, this situation give you the opportunity to obtain demographic information, but do you also consider the patient's need for an interpreter at that point?

"We have a window of opportunity to identify the patients coming into our facility that will need some form of interpreter services," says **Jacqueline Doerman**, patient access services manager at the Patient Accounts & Access Center at OSF Healthcare in Peoria, IL.

At Oregon Health & Science University Hospital in Portland, many documents given at registration are translated into the major languages seen in its hospitals and clinics, including Spanish, Russian, Mandarin Chinese, and Vietnamese.

The Civil Rights Act of 1964 has requirements for providing interpreter services, and Medicare

EXECUTIVE SUMMARY

Patient access are identifying non-English speaking patients' needs for interpreter services earlier in the process with pop-up screens and scripting. Other ways to meet patients' needs:

- Remind registrars to assess interpreter needs at the point of scheduling.
- Encourage registrars to identify documents that need translation.
- Train patient access staff as interpreters.

Conditions of Participation also require providing interpreter services and available documents be available in the major languages served, notes Ronald Marcum, MD, director of the organization's integrity office.

"The documents are translated through our interpreter services using the same qualification requirements used for direct medical care," says Marcum. The documents that are readily available in other languages include the Notice of Privacy Practices, many standard instructions for patients for medical conditions, and a number of educational documents informing patients about their illness.

OSF Healthcare's financial clearance center calls patients having high-dollar diagnostic testing, so a need for an interpreter is sometimes identified then, says Doerman. "We also have a notification in our computer system if someone will require an interpreter," she says.

At Cincinnati (OH) Children's Hospital Medical Center, scheduling center agents use a script at the point of scheduling to assess if an interpreter is needed. "We try to do the assessment before the patient gets here, but sometimes we don't discover that an interpreter is needed until the patient arrives at registration," says **Michelle Gray**, MHA, director of patient access and outpatient registration.

Registrars don't have patients sign any consent paperwork that isn't in the patient's native language, adds Gray. "Our challenge is not having everything translated in all languages we would like to have," she says. "It probably isn't realistic to have everything you need translated in every language as patients present." *(See related story, p. 8, on training patient access staff as interpreters.)* Here are ways patient access leaders are meeting the needs of non-English speaking patients:

• At OSF Healthcare, registrars have access to interpreters as well as a mobile interpreter cart.

The video remote cart (manufactured by Wenatchee, WA-based InDemand Interpreting) allows registrars to communicate through an interpreter in the patient's native language via videoconferencing. (For more information, see resource at end of this article.) "This cart was tested at one of our facilities with great success and was, therefore, implemented at two other locations," says Doerman. "Training sessions were offered to our staff to know how to operate the cart."

• Patient access employees at Cincinnati Children's are encouraged to identify documents that need translation in a specific language.

If a registrar notices a significant number of patients are native speakers of a particular language, he or she might be unaware how to make a request for documents to be translated in that language.

"We need to do a little better job of empowering our frontline people to say, 'This document needs to be translated,'" says **Ricardo A. Torres**, CMI, CFLI, manager of linguistic services for the hospital's Office of Diversity & Inclusion.

"It's important that we let people know what the process is to get something translated, so they are part of the solution to identify gaps," says Torres. "We rely heavily on the various staff members. If they say a document is not available in a particular language, we get that translated as soon as possible."

• At Cincinnati Children's, documents that involve consent aren't being sight-translated (read out loud to the patient in his or her native language) to be consistent with the way this situation is handled with English-speaking patients.

"In reality, not even English-speaking people are reading the entire documents," Torres explains. "They rely on the provider to understand what they are signing. We encourage our providers to go over the consent just like they would with an English-speaking patient."

SOURCES/RESOURCE

For more information on meeting the needs of non-English speaking patients, contact:

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• **InDemand Interpreting** provides video remote interpreting services for the healthcare industry, accessed over stationary, cart-mounted and mobile video-capable computing devices. Customers pre-pay for minutes using bundled service plans that include the provisioning of end-user interpreting stations, based on the number of minutes in their plan. For more information, contact InDemand Interpreting, Wenatchee, WA. Phone: (877) 899-3824. Email: sales@indemandinterpreting.com. ■

Train registrars as interpreters

While some patient access employees at Cincinnati (OH) Children's Hospital Medical Center were bilingual, they weren't qualified to serve as interpreters. Now these employees will be offered training based on Kaiser Permanente's Qualified Bilingual Staff Model and Program. *(See resource at end of article for information.)*

"There will be a huge emphasis in allowing individuals to go through this process," says **Ricardo A. Torres**, CMI, CFLI, manager of linguistic services for the hospital's Office of Diversity & Inclusion. "This is one of the biggest goals we have as an organization in fiscal 2013."

Torres says the organization could see significant benefits as a result of being able to use patient access staff as interpreters, depending on the number of personnel able to pass the screening test and successfully complete the training, "Currently, the cost of all interpreting services is being allocated to the office of Diversity and Inclusion," he notes.

A vendor (Atlanta-based Alta Language Service) is performing the language proficiency assessments and determining which of these three levels the employee is qualified for:

Level 1: Bilingual staff who has demonstrated enough conversational skills to interact with patients at basic levels. They will receive the Qualified Bilingual Staff eight-hour training.

Level 2: Bilingual staff who has demonstrated a higher level of proficiency in the language in question. They will receive the full Qualified Bilingual Staff 24-hour training, which includes basic introduction to skills and knowledge needed to function as an interpreter, clarifier, mediator, and advocate.

Level 3: These are individuals with much higher command of both languages with knowledge of medical terminology. They will receive the same Qualified Bilingual Service 24-hour training, but their scope of practice would be comparable to a regular spoken interpreter.

"Registrars will probably be doing Level 1, because they won't be expected to know medical terminology," says Torres. "Depending on their level of proficiency in the language they speak, they can interact directly with the patient."

RESOURCE

• Kaiser Permanente developed the **Qualified Bilingual Staff (QBS) Model and Program** in response to the increasing demand for linguistically and culturally appropriate services for its non-English or limited-English proficient patient populations. The QBS Model and Program provides bilingual employees specialized education and training to maximize their diverse linguistic skills and contribute to improving the overall patient care experience. This Model and Program is available to organizations at no cost. For more information, contact Oscar Lanza, Manager, National Linguistic & Cultural Programs, National Diversity, Kaiser Permanente, Oakland, CA. Phone: (510) 271-6868. Fax: (510) 271-5757. Email: Oscar.Lanza@kp.org. Web: http://kpqbs.org. ■

Access has role to prevent penalties

ID problems causing avoidable readmissions

Hospitals are getting penalized for preventable readmissions, due to the Patient Protection and Affordable Care Act's linking of Medicare payments to the quality of care that hospitals provide. Hospitals can lose up to 1% of Medicare inpatient revenue in Federal Fiscal Year (FFY) 2013, 2% in FY 2014, and 3% in FY 2015 and beyond.

Patient access areas have a "tremendous opportunity to help develop a holistic understanding of patient's needs" by collaborating with case managers and discharge coordinators to prevent these costly penalties, according to **Chad Mulvany**, technical director in the Washington, DC, office of the Healthcare Financial Management Association (HFMA). "It's well-documented in any number of studies that economically challenged patients are more likely to be readmitted," says Mulvany.[1,2]

It's more difficult for individuals who lack of financial resources to obtain medications and follow-up

EXECUTIVE SUMMARY

Hospitals face significant loss of revenue due to preventable readmissions, due to penalties of up to 1% of Medicare inpatient revenue in 2013. Patient access areas can prevent this by:

- collaborating with case managers and discharge coordinators;
- understanding that some readmissions are caused by psychological or social issues;
- ensuring that patients have clear instructions and solutions to related medical issues.

care, which contributes to an increased probability of readmissions, he explains. "In many instances, patients are hesitant to discuss financial issues with caregivers. However, patient access areas and financial assistance counselors certainly are aware of resource issues," says Mulvany.

Not just clinical issue

The first step is for patient access leaders to understand the problem, says **Dan Schulte**, executive vice president of revenue cycle solutions for The Outsource Group in St. Louis, MO.

"Readmission is a clinical issue only at the first glance," he says. "Look below the medical illness causing the readmission, and likely you will see a psychological issue or a social issue." It might be that a patient has mental illness or incapacity that is preventing good decision-making, is homeless, or has a home that is not conducive to post-admission care.

"Patient access can help by ensuring that the discharge coordination efforts include the members of a successful cross-functional team: clinical, social work, and finance," says Schulte. The goal is to ensure that patients have clear instructions, solutions to related medical issues, and a safe harbor when they leave the hospital, he explains.

"I spent many years working on all three sides of the emergency room, as a unit secretary, a registration/finance manager, and a community activist," says Schulte. "If we could join together as clinical, administrative, and community leaders to address the 'biopsychosocial' issues of these patients, we could significantly reduce a number of problems."

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Collections rise by 25% — The reason? Bonuses

$500 quarterly incentive is possible

Collections surged by 25% the first year after a bonus program was implemented in 2010 at The University of Tennessee Medical Center in Knoxville. "We are on track to collect $3.8 million this year," reports **Brad Davenport**, director of patient access.

Over the decade patient access employees had collected copays, collections typically increased 5% to 6% each year. However, the yearly increase was 8% to 9% for the second and third years after the incentive was added.

"All patient access employees are eligible for the bonus, because they all have a role to play," says Davenport. "Insurance verification, preregistration, and preservice all have to flow together."

Staff members are eligible to receive a $500 bonus quarterly if they meet both a collections goal for their area and additional criteria on these metrics, measured by the department's recently implemented registration quality system:

- for scheduling areas: average hold time of less than 30 seconds, and abandoned call rate of 2% or less;
- for registration areas, including the emergency department: 98% of registrations error-free, and a duplicate medical record rate of less than 1%;
- for precertification and order management areas: less than nine preventable precertification-related denials per quarter, and less than 1.3% of scheduled patients delayed due to an order or precertification issue.

Anything collected up to five days after discharge counts toward the collection goal, such as if a patient calls to make a payment with a credit card, and prior balances also are counted. "A patient may come in for a scheduled service and owe balances on several prior visits. This gives staff an incentive to look for that," says Davenport.

If areas haven't met their goal for two or more quarters, "we put it out in front more," says Davenport. "But at times, the ED has very high volume, and collections take a back seat. Sometimes you've just got to survive, and collections is usually the first thing to be pushed aside."

Before the bonus program was rolled out, patient

EXECUTIVE SUMMARY

Collections increased by 25% the first year after a bonus program was implemented in 2010 at The University of Tennessee Medical Center, and they have increased 8% to 9% for the past two years.

- Staff must meet a collections goal and additional criteria.
- Prior balances and amounts collected post-discharge count toward the collections goal.
- Emergency department registrars have a lower goal because collecting is more difficult.

access leaders struggled to determine the amount of the collection goals because they wanted to make these challenging to meet, but not impossible, Davenport explains.

"We based the collection amounts mainly on our historical data of collections increasing by about 5-6% a year, and bumped that up a little bit," he says. "But we found that for some areas, this wasn't high enough to start with."

ED had lower collection goal

A lower collection goal was set for the emergency department due to higher turnover, patients being unprepared to pay, and increased patient volumes, but this was increased gradually by 10% over six months, says Davenport. Of the $3.2 million collection goal the department set for this fiscal year, the ED collections goal is $540,000, and the goal for other point-of-service collections goal is $2.66 million.

To help staff collect, financial counselors were given the ability to approve prompt-pay discounts of 10% if patients cleared their balance on the spot.

The department is working to identify specific missed collection opportunities, such as the inability of staff to give accurate price estimates to patients, says Davenport. This process is done manually, but the department is looking into investing in a payment estimation system, which would allow staff to feel more confident in collecting the patient's out-of-pocket responsibility, he says.

"We would be able to give patients something to show how the amount was arrived at," Davenport says. "Some payers, though not all, allow you to do that on their web pages, but we haven't been too successful with that." This problem is primarily due to lack of accurate CPT codes at that time, he explains.

"Copays are simple to collect. There is not a whole lot of argument there. But on big accounts such as surgeries, staff may not feel comfortable presenting an estimate," says Davenport. This situation often happens if the patient is sure they have met their deductible and staff members know the deductible they are seeing isn't accurate, he adds.

Missed opportunities identified

The registration quality system will give patient access data on how many patient accounts converted to self-pay after insurance.

"This will help us determine the missed opportunities, so we can give better estimates," Davenport says. "Then we can back track to see why that wasn't collected on the front end."

When the registration quality system is fully implemented, that situation will pave the way to offering employees an individual collection goal, he adds. There is some occasional grumbling about employees not pulling their fair share of collections, says Davenport, who adds that when the final payment is made, an adjustment is made for the employee's productivity hours put in for that quarter. If an employee takes a week vacation during that time, for example, the commensurate amount is deducted from the bonus he or she receives.

"We have 130 edits currently. All registrars have their own worklist, so when they come in every day, they can see the registrations from the previous day that need a correction," says Davenport. "We are now getting reports showing quality scores. We hope to give a report card to every employee." *(See related story, below, on customer service and collections.)* ■

Collect, but give excellent service

When a bonus was first offered to registrars at the University of Tennessee Medical Center in Knoxville for meeting specific collection amounts, customer service was top of the mind for patient access leaders.

"We talk a lot about collections and service, and how to balance the two," says **Brad Davenport**, director of the hospital's Patient Access Center. Most inpatient areas are well above 80% percentile in satisfaction scores, he reports.

"You can maintain good customer service while collecting. It can be done," says Davenport. "We really promote respect for patients, with the idea that we may not be collecting from everyone, but we talk and counsel with everyone."

Staff members take a positive approach to collections, saying, for example, "We have verified your benefits, and your insurance will pay very well. This is what we think your responsibility will be." It might be that staff members need to explain the process and the different payment options to a particular patient who pays the balance later in the process, Davenport explains. Patient account representatives use this script when collecting:

"Hello, my name is _____, and I am your patient account representative here at the ___Medical Center. I would like to spend a few minutes discussing some financial matters related to your visit. Is now a good time for you to talk? (If no, ask when would be a more appropriate time). My goal is to make our

billing process as painless as possible. We have been in contact with your health insurance and want you to know that everything looks to be in good order. I also want to show you our Understanding Your Hospital Bill brochure, which explains our financial policy and has some important phone numbers. This is a letter explaining the hospital charges so far. We estimate that you will be responsible for _____. That can be paid by cash, check, Visa, MasterCard, American Express, and Discover. I can take your credit card information now if you like."

While the script isn't followed word for word, the message that staff give to patients must be consistent, he says. "We really instilled that, 'If this is how you present it, we will back you up,'" says Davenport. "If you do your own method of collection, that's when you get into trouble." Phone calls are recorded in all areas that collect except the emergency department. "That helps our financial counselors in a few ways," says Davenport. "If there is a complaint, it helps us critique it. We also use the calls for training." ■

Patient ID pitfalls plague HIE networks

As patient access staff well know, managing patient identities is one of the hidden problems of health information exchange (HIE) and electronic health record (EHR) technology, according to the National Association of Healthcare Access Management (NAHAM).

Every patient needs a single and unique identifier tied to his records, and a simple typo or a misspoken birthday can leave a patient with duplicate records, which potentially compromises his or her care.

Many hospitals use their own master patient indexes (MPIs) to check if patients have an existing record, but the emergence of HIE means new challenges in ensuring accuracy across multiple providers for millions of new patients. Unique identifiers must be the same across the entire HIE for the network to function, and NAHAM has been working to provide a toolkit to members to assist with that goal.

According to a white paper on EHR Intelligence, establishing a unique identifier can also be accomplished with the help of a systemwide enterprise MPI (EMPI). *(To access the white paper, go to http://bit.ly/StZLrl)*. An EMPI provides its own identifier that spans the entire network, which requires accurate and complete data across every department or healthcare provider contributing to a patient's care.

Quality control during the admissions process is the first step toward ensuring accuracy, but employees performing the data entry often are under conditions that require them to be as speedy as possible. Mishearing the spelling of a surname or transposing a letter in a street address can accidentally create an entirely new record and identification number for a patient who might have visited the facility before. Without consulting the patient, it's nearly impossible to tell if the original data is correct or if a mistake was made previously and the new input is the proper information. Implementing safeguards in patient record software to prevent these small mistakes might seem like an easy task, but human error always will find a way to defy technology, NAHAM says.

HIE vendors are trying to work around these problems with a variety of innovative ideas such as biometric data or cloud-base solutions, but patient records continually are developing collections of changeable data. The goal of HIE and EHR is to manage this data cleanly, effectively, and with the maximum benefit to the patient, but the margin for error only grows wider as more and more providers try to collaborate and share information.

HIE systems must be capable of preventing mistakes caused by duplication or accidental deletion of records, but healthcare providers themselves ultimately are responsible for being certain that the patients in front of them matches the information on their computer screens. ■

More states require photo ID for voting

Controversy over photo identification has been in the news a lot in recent months, specifically in regard to laws passed by some states that require photo identification when voting, according to the National Association of Healthcare Access Management.

COMING IN FUTURE MONTHS

- Zero in on missed collection opportunities
- Find out the real truth about staff satisfaction
- Give staff training to prepare for healthcare reform
- Learn pros and cons of registrars working from home

These laws, however, have an effect outside the voting booth as well. Are you who you say you are? Have you been here before? Sound familiar?

National Public Radio (NPR) ran a story analyzing a study from the Brennan Center for Justice at New York University's School of Law. The study, "Voting Law Changes in 2012," looked at the population of U.S. citizens who don't have identification to use for voting. The NPR article can be found at http://n.pr/yPenNs. The study can be found at http://bit.ly/nZWvCn.

The study indicates that in the 2012 elections, millions of Americans found that since they last voted, and for many that would be 2008, there were new barriers that could prevent them from voting. At least thirty-four states introduced legislation that would require voters to show photo identification to vote. Photo ID bills were signed into law in seven states: Alabama, Kansas, Rhode Island, South Carolina, Tennessee, Texas, and Wisconsin. By contrast, before the 2011 legislative session, only two states had ever imposed strict photo ID requirements.

The study also shows that 89% of the U.S. population has some form of photo identification, while the remaining 11%, about 3.2 million people, do not. Most of the 11% without identification fall into one of four categories: the elderly, minorities, the poor, or young adults aged 18 to 24.

The Brennan Center estimates that 18% of all seniors and 25% of African-Americans don't have picture IDs.

Here's how NPR reports it:

Many people have multiple forms of identification, including those that display their pictures, such as employee badges or credit and debit cards. But states with strict voter ID laws require people to have certain photo IDs issued by governments … That typically means driver's licenses. But many seniors and many poor people don't drive … And many young adults, especially those in college, don't yet have licenses … A good number of these people, particularly seniors, function well with the identification cards they have long had, such as Medicaid cards, Social Security cards, or bank cards.

Not to worry. If you really need photo identification, NPR reports that many states offer non-driver identification cards that can be displayed when voting, often provided by motor vehicle agencies. But here is an interesting Catch-22: "to get an ID, you need an ID."

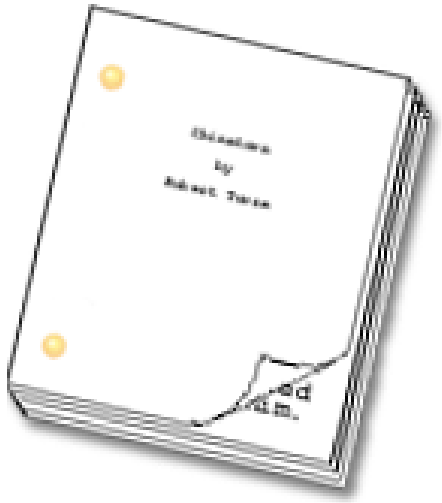
In most states with voter identification laws, citizens must present birth certificates to obtain new photo identification cards. If a state does have a person's birth certificate, they often must present a photo identification card to obtain a copy. NPR continues its reporting based on the focus on these laws and the impact they have on individuals who find they might not be able to vote.

Shift to the healthcare setting. The Kaiser Family Foundation (KFF), in the report "Characteristics of Frequent Emergency Department Users" (found at http://bit.ly/kx0Cml) stated that about 20% of "high emergency department users" are 65 and older, and 37% of emergency department patients are poor and near poor. These numbers reflect a significant part of the population that is unlikely to have photo identification. ■

Importance of Scripting

Standardized scripts have been developed and will be required to be followed at all sites that schedule appointments throughout CHA.

This will allow CHA to achieve consistency throughout the Alliance when interacting with patients over the phone



Scheduling Scripts: Introduction

Phone rings:

"Thank you for calling the _____clinic/ health center, my name is _____. How may I assist you today?"

Patient indicates they wish to schedule appt with provider:

"Could I get your first and last name please? Thank you Mr. / Ms. _____. In order to schedule your appointment today, I will need to collect some information from you at this time."

Scheduling Scripts: Information Gathering

The scheduler will gather the information needed for the appointment by asking the following questions:

"Can you please spell your (first and last) name for me"

"What Month, Day and Year were you born?"

"What is your social security number?"

At this point, the scheduler has enough information to determine if the patient is a new patient or not.

"What is your reason for making this appointment today?"

"Are you male or female?"

"What is your current address?"

"What is the best phone number to reach you? What is the second best phone number to reach you?

"Who is your primary care physician? Who is the referring physician?" (specialty clinics only)

"Are your health concerns due to a motor vehicle accident or accident at your work?

"What is the name of your health insurance?

Scheduling Scripts: Closing the Call

Does the patient meets pre registration criteria (Yes / No)?

<u>Yes</u> - Patient will be transferred to the pre registration department

"Before your appointment is complete, a registration specialist will have a few last questions for you in order to process your appointment. Thank you for choosing CHA. Please hold the line for just a moment."

<u>No</u> - Call is completed – a pre registration is not necessary at this time.

"Thank you for choosing CHA. Do you know where to go for your visit? *(if yes give directions)* At this time , do you have any additional questions for me? If not, we'll see you on the _____(date) at _____ (time). Please remember to bring a picture ID, insurance card and your copayment due." Thank you and have a great day"

Scheduling Transfer Compliance

- Mechanisms have been created in EPIC to track scheduler compliance with transferring appropriate calls to the pre registration department

- Data around the number of calls being transferred to pre registration will be compiled and shared with scheduling staff and managers in each area

- **IT IS VERY IMPORTANT THAT SCHEDULERS FOLLOW THE PRE REGISTRATION CRITERIA AND TRANSFER PATIENTS WHEN APPROPRIATE !**

Additional Scheduling Notes

- EPIC alerts have been created. These alert messages will automatically appear on the screen immediately following the scheduling portion of the intake process.
- Given the importance of transferring calls from scheduling to pre-registration, **managers will monitor staff compliance very closely using QA reports** that have been developed. Feedback also will be provided to scheduling staff on a regular basis.
- In most cases, scheduling an appointment should not require additional time. Alerts in Epic will prompt and guide the schedulers based on the programmed criteria in EPIC.
- For appointments that are made by a provider office or other third party, the patient will be contacted by the pre registration department via an outbound call. The appointment will appear on an outbound call queue for pre registration staff to work. Several attempts will be made to contact the patient before the date of service.
- Pediatric "meet and greet" appointments should never be transferred to pre registration

"Hello, Cambridge Health Alliance Pre Registration Department, My name is _____; Mr._____, Mrs._____, or Miss_____.
I am going to help you today pre register for your appointment scheduled on _____ (date, time, location, & with provider). Who referred you to this appointment (or verify the information scheduling put in.) "I see "provider" referred you for this appointment.

Can you please state the month, date and year of your birth (wait for response), your current address is (wait for response), social security number (wait for response) and the best telephone number to contact you____, second best telephone number. May I have your email address____?

I need to verify the following information your sex, marital status, religion, race, and ethnicity, language spoken and written.

I need to also verify your veteran status, and ask if you have a healthcare proxy. (Answer questions regarding proxy).

Who is your employer, where are they located and what is their phone number? What is your occupation there? (Fulltime, part time, etc)

Who is your preferred emergency contact and next of kin?

During the above process, the pre registration staff, should be able run verification of insurance listed on EPIC through Nehen, or Web MD.

Can we please verify your insurance. Who is your insurer? (policy #, group#) Who is the subscriber or carrier of your health insurance? Do you have any other insurance?
Depending on the information obtained through the insurance verification process the following will be addressed guarantor, referral/authorization, MSPQ, occurrence, accident guarantor, insurance product detail information, and PCP.

Based on the insurance product information obtained through the verification process the pre-registration process with follow the following scripted guidelines:

- ✓ **Self pay**
- ✓ **Insured CHA patient**
- ✓ **Insured Non-CHA patient**
- ✓ **Noncontract payer**

2012 SALARY SURVEY RESULTS

FOR MORE THAN 30 YEARS

Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

Salaries will grow, but only with additional skill sets

Service and technology expertise are seen as paramount

At Emory Hospitals in Atlanta, patient access salaries reached parity with business office salaries many years ago, reports **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle management.

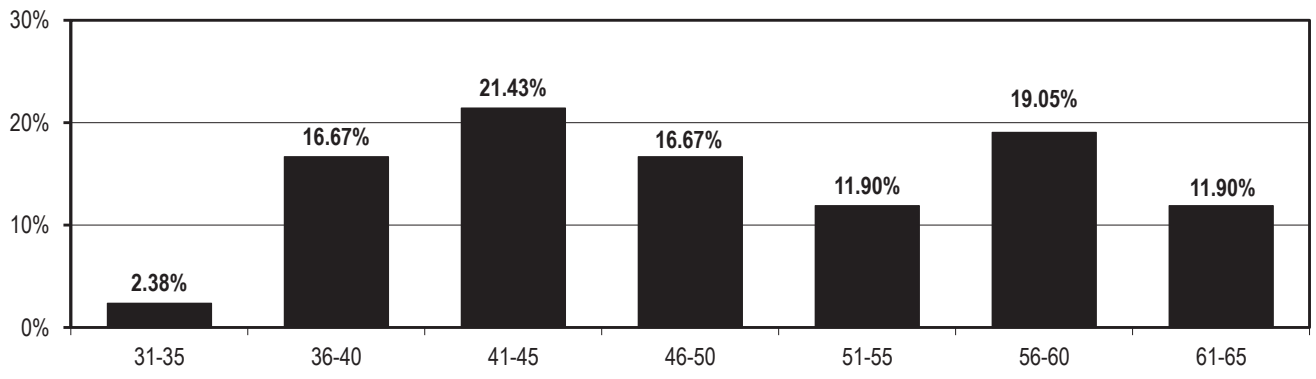
"As access continues to assume many traditional back-end functions and requires broader, yet highly specific knowledge of healthcare intricacies, I think the argument can be made for access surpassing business office salary scales," Kraus adds.

As healthcare costs increase and margin is an issue, it might be difficult for organizations to "welcome" upward salary adjustments, says **John Woerly**, RHIA, CHAM, FHAM, senior principal at Accenture Health Practice in Indianapolis. "However, the skill set and expectations required of the 'new' patient access leader and staff member requires a higher salary range than perhaps traditional pay," he adds.

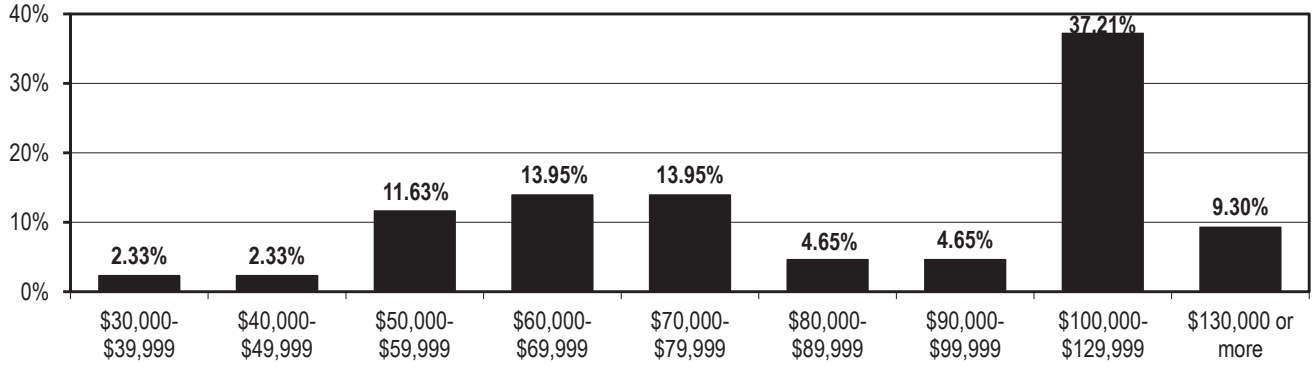
Healthcare organizations are realizing that front-end operations greatly impact clinical and financial outcomes, Woerly says. "If not done correctly the first time, rework and process gaps occur and are more costly," he says.

At University Hospital of Arkansas in Little

What is your age?



What is your annual gross income?



Rock, although patient access salaries still are slightly below those of the business office, the human resources department is conducting a market survey to determine if this should change, says **Holly Hiryak**, RN, CHAM, director of hospital admissions. "We may find that an adjustment is needed, but I do not think that we can financially afford to adjust at this time," Hiryak says. "Manager salaries are in line with our business office. But some of the [patient access] managers have 24/7 responsibility, so they really should be higher."

Patient access has always been about information gathering, "and that part won't change," according to **Mitch Mitchell**, president of T.T. Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology. However, Mitchell says that what is changing is that hospitals are collecting information earlier in the process and, in some cases, allowing patients to submit it electronically.

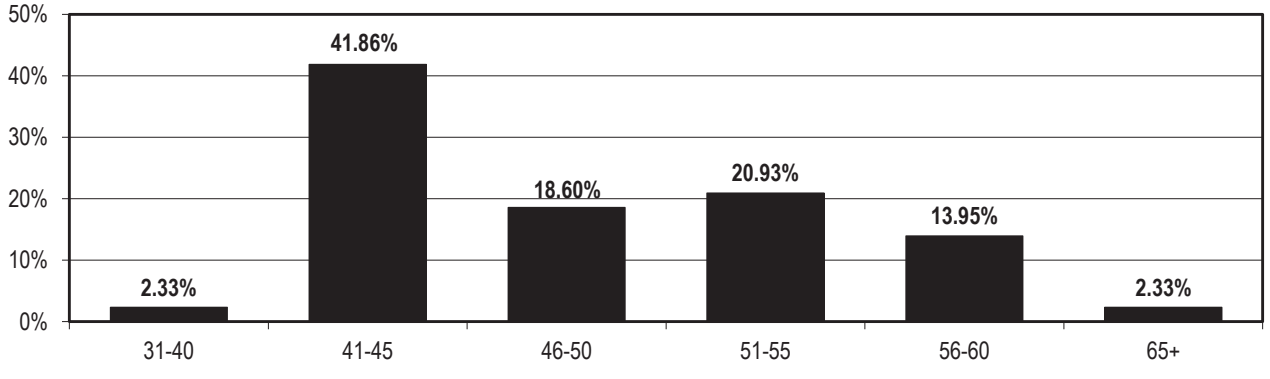
Because the registration role is becoming more crucial to getting bills out more quickly and accurately, "it's becoming apparent that the front line people are being paid way too little," says Mitchell. "What registration does is equal to the work billing personnel does. It takes billing people away from having to look at as many bills upfront. It allows them to concentrate on what's not being paid for other reasons."

For pay to grow, so must responsibilities

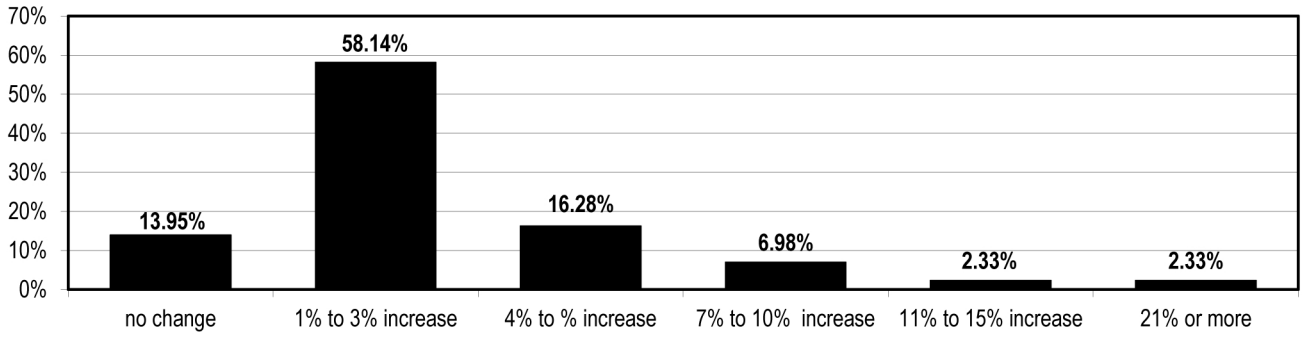
Patient access salaries will increase, but only if roles are expanded, according to **Charlene Cathcart**, CHAM, director of admissions and registration at Palmetto Health Richland in Columbia, SC.

"I see salaries changing only if we are able to add additional skill sets to the role," she says.

How many hours a week do you work?



In the last year, how has your salary changed?



"You may have a cross-functional patient access representative and financial counselor, or team members that can schedule a patient for services and then complete the pre-registration process."

Other skill sets that might command higher salaries are ancillary services check-in, including providing screening tools such as a CT scan screening form, and validation of the patient's order, says Cathcart.

According to the 2012 *Hospital Access Management Salary Survey*, 12% of respondents earn between $50,000 to $59,999, with 5% earning less than that amount. Another 14% earn between $60,000 and $69,999, 14% earn between $70,000 and $79,999, and 47% make $100,000 or more. *(See chart, p. 2.)* Fifty-eight percent of respondents reported a 1-3% increase in salary in the last year, and 16% received a 4-6% increase. Only 2% received an increase of 11% to 15%, and 14% reported no change. *(See chart, above.)*

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 2012 report, 704 surveys were disseminated. There were 43 responses, for a response rate of 6%.

Other key findings of the survey:

- Forty-two percent of respondents work between 41 and 45 hours, and 19% work between 46 and 50 hours. More than one-third (37%) put in more than 50 hours. *(See chart on p. 2.)*
- Sixteen percent of respondents have worked in patient access for three years or less, and 14% have worked between four and six years. Nineteen percent have worked in patient access for 25 or more years. *(See chart on p. 4.)*
- Forty-three percent of respondents were older than age 50. *(See chart on p. 1.)*

Front end in spotlight

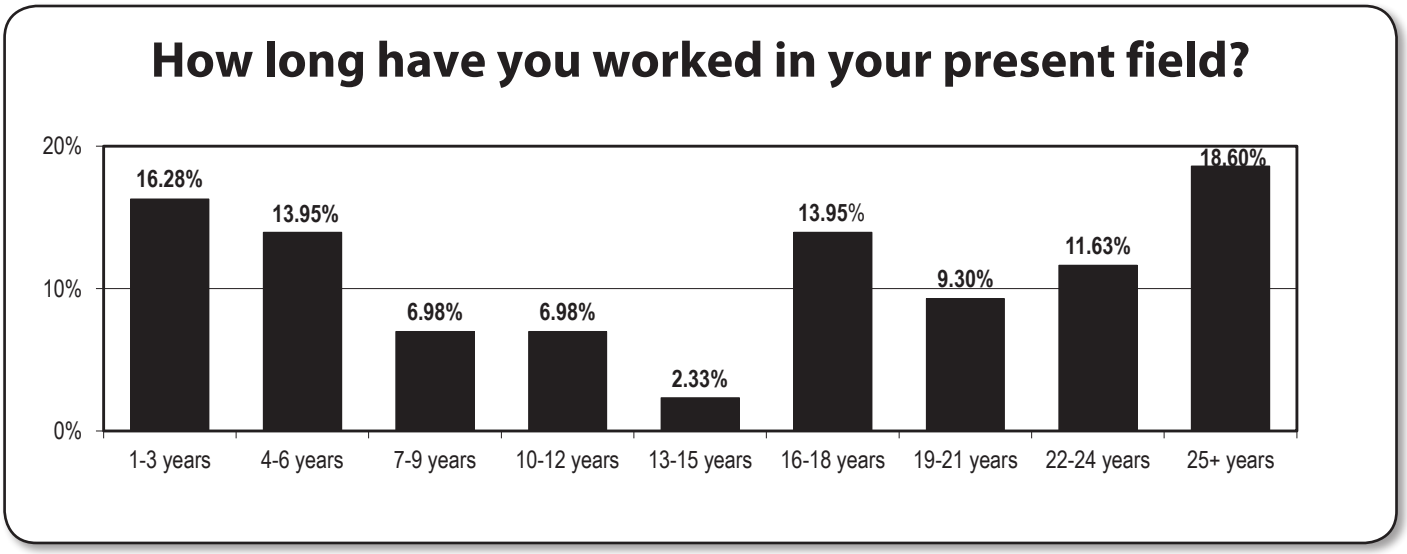
Traditional "preadmit" activities, such as demographic data collection, insurance verification, medical necessity, and financial clearance, are increasingly being done at the time of scheduling.

"We are pushing the front end even further up front, by taking over radiology scheduling and phasing in centralization of other scheduling activities," reports Kraus. "The ultimate goal is that no patient is scheduled without these prerequisites being completed."

Patient access staff at University Hospital of Arkansas are getting additional customer service training, including how to communicate financial information at the time of scheduling without offending patients. Schedulers are being trained to perform additional registration and coordination of benefits activities at the time of scheduling.

"Increased knowledge in scheduling, billing, and systems integration is becoming more important," says Hiryak. "This makes the knowledge base required to do the job significantly more complex."

Woerly predicts that the trend of moving revenue cycle activities to the front end will continue to grow. "This will require new technologies and/



or the optimization of [information technology] systems to support these needs, as well as the development of staff skills to fully optimize these systems," he says.

There is a growing focus on the understanding of and the communication of patient liabilities and various funding resources, Woerly says. "This is a new accountability for many patient access departments," he says. "It requires both process and technology redesign to successfully operationally deploy and to sustain."

New skills needed

Kraus sees an increasing need for patient access employees to have clinical, financial, and regulatory knowledge, the ability to work with multiple systems, and the ability to provide education to patients who don't understand the financial and technical aspects of their healthcare experience.

Registration people need to know more about what's covered and what isn't, especially in light of healthcare reform, says Mitchell. "For decades, we've told patients it's up to them to know what their insurance covers," he says. "But the reality is that it impacts the hospital. Thus, it should be hospitals making sure they know what insurances cover or not. They should be prepared to explain that to patients when they come in."

To be successful in this endeavor, patient access managers need top-notch leadership skills to be sure employees are updated on changes, motivated, and feeling good about the job they do, emphasizes Mitchell.

"Registration staff are usually not considered as professional and knowledgeable as other staff within the hospital," Mitchell says. "But they're very crucial to the financial survival of the hospital. Their importance needs to be recognized."

Cathcart says the world of patient access will continue to become more customer-service oriented. "Patient-centered care will be the area of greatest focus for training, from basic customer services to service recovery," she underscores.

The single most important skills for patient access leaders are adaptability and being able to handle sudden changes in processes or even reporting structure changes, says Weatherman. Front-end staff are working with integrated systems including kiosks, online registration, eligibility systems, portable work stations, electronic signature capture, and "the list goes on and on," he says.

Weatherman says that after being in the patient access field for 35 years, he has seen the role change a great deal, except for one thing. "Registrars remain the usual first contact for our guests and patients," he says. "Customer service remains a vitally important skill that registrars must possess." ■