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## IN THIS ISSUE



AHC Media

# Don't let patients' financial worries make access into the adversary

*New role for registrars presents opportunity: Offer them help*

If you're the one who tells self-pay patients their bill is in the six figures without offering any assistance, they're very likely to "blame the messenger" and become defensive. On the other hand, what if you could give those patients peace of mind by helping them obtain desperately needed coverage?

"When registrars present the estimate to the patient, it can be quite a surprise," says **Kym Brown**, BA, CHAM, manager of patient access at Saint Elizabeth Regional Medical Center in Lincoln, NE. "Patients may be upset about their estimated amount, that we asked for payment, or just due to the stress of their situation."

Registrars go out of their way to explain the estimate, involve financial counselors on the spot, and offer information on setting up payment arrangements or filing applications for financial assistance. "Patients are generally relieved at these extra efforts from staff," says Brown. "Registrars are sometimes the first person to hear about the patient's financial struggles."

Patient access is usually the first contact a patient or family member has when they come into the hospital and the first opportunity to collect the patient's out-of-pocket responsibility, says **Mitch Mitchell**, president

## EXECUTIVE SUMMARY

Patient access staff can give self-pay patients peace of mind by helping them obtain coverage, completing applications, and acting as an ally in the approval process. The Trinity Rock Island (IL) campus collects about $150,000 a month of additional revenue by identifying Medicaid-eligible patients.

- Some patients are reluctant to provide necessary information.
- Demographics information can determine whether the patient meets criteria.
- Coverage can improve compliance and prevent readmission.

of T.T. Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology. "Customer service is paramount. But hospitals deserve to get paid, just like any other entity," he says.

At Trinity Rock Island (IL) 15% to 20% of patients are self-pay, and the hospital collects about $150,000 a month of additional revenue by identifying Medicaid-eligible patients, says **Linaka Kain**, the hospital's disability examiner/Medicaid specialist. "We have been able to convert roughly 16% to Medicaid and the rest to charity," Kain reports. "We increased our amount of Social Security disability/Medicaid approvals by 15% last year. These patients were initially self-pay."

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## Know all options

The hospital is seeing a spike in self-pay patients between the age of 60 and 64, says Kain. "There is a huge hole there. They aren't old enough for Medicare, are either working a part-time job or not working, and they are not insured," she adds.

The challenge is to figure out how to help a patient in this group, who is going to be placed in a long-term setting for rehabilitation, obtain coverage, she says. "A lot of nursing homes won't take self-pays if they are not in a pending status for Medicaid," Kain explains. "We can't have them in the hospital for months on end, because they don't meet the criteria."

Most patients in this situation apply for financial assistance from the hospital. "When it comes to financial assistance and what programs are available, we have to stay a step ahead," Kain underscores. For example, Iowa won't process any paperwork for Medicaid if the patient isn't already on Social Security disability, whereas the state of Illinois will begin processing the application if proof of filing is provided.

"Knowing that makes a huge difference in whether a patient will end up being eligible," says Kain."If we are not on top of what is going on out there, we will end up with a ton of charity write-offs."

As a not-for-profit hospital, the charity program is always used as a last resort of payment, she explains. "It is far better for our patients and the hospital to advocate for them and get them eligibility in a funding source if we can," Kain says.

## "Two-way street"

Some patients start out insisting that the hospital simply write off the entire amount of their bill, says Kain. In this case, patient access staff members educate them about the patient's role in the process. *(See related stories on how to maintain satisfaction, p. 27, getting patients to provide information that could help them obtain coverage, p. 28, and preventing readmissions, p. 28.)*

"Some people think they should have everything for free. We explain to them that it's a pot of money and a lot of people are dipping into the pot, so we just can't write everything off for someone," she says. "The patient has to participate. It's a two-way street."

The patient has to sign paperwork and might have

to go to the Medicaid office after being discharged, for example. In many cases, though, applications for Social Security Disability, Medicaid, or both, are filed before the patient is discharged. "Sometimes I get an answer on both before the patient even goes home, which is a godsend for them," says Kain. "It's another thing they don't have to worry about."

After her first meeting with an inpatient, Kain checks in a day or two later if the patient is still in the hospital to see if anything has changed. "The patient may come in with one illness, but after a day or two goes by, you realize everything has changed drastically," she says. The patients might have been diagnosed with a condition that requires long-term care, for example, which makes them eligible for a certain type of coverage.

"Some people think it's not a good idea to tell people how much their bill is, but I disagree," says Kain. "People need to understand how expensive things are, because they have no idea. Patients think open heart surgery and rehabilitation costs around $10,000, but it's over $150,000."

Once Kain completes a patient's application, she explains that Medicaid is being asked to cover services retroactively, and then she tells the patient not to open the bills they receive in the mail. "I tell them, 'Just put them in a stack — don't stress yourself out. We will need to give them to the Medicaid office, but we will deal with that when the time comes,'" says Kain.

**SOURCES**

For more information on helping patients obtain coverage, contact:


• **Kym Brown**, CHAM, Manager, Patient Access, Conifer Health Solutions/CHI, Saint Elizabeth Regional Medical Center, Lincoln, NE. Phone: (402) 219-7316. Fax: (402) 219-7199. Email: Kbrown@stez.org.

• **Linaka Kain**, Disability Examiner/Medicaid Specialist, Trinity Rock Island (IL). Phone: (309) 779-2648. Email: Kainll@ihs.org.

• **T.T. "Mitch" Mitchell**, President, T.T. Mitchell Consulting, Liverpool, NY. Phone: (315) 622-5922. Email: mitch@ttmitchellconsulting.com. ■


# Be more efficient with registration

*It boosts satisfaction*

By creating a more efficient registration process, the percentage of patients stating they were "satisfied" or "very satisfied" in response to the survey question, "How satisfied were you with the registration process?" rose from 50.7 % to 58.5% positive in just one month at Saint Elizabeth Regional Medical Center in Lincoln, NE.

"This score placed us in the 67th percentile nationally," says **Kym Brown**, CHAM, manager of patient access. "In the past year, we have really put the focus on increasing patient satisfaction."

Outpatients are now pre-registered with a "fast-track" process. "Patients spend less time in a registration office — at least eight minutes less, on average," says Brown. "All pre-registered patients are registered by an access employee whose focus is a 'quick in and out' of the registration department." These steps occur:

• The patient is pre-registered prior to the visit.

• The patient arrives in admissions, with paperwork picked up by a designated group of fast-track registrars.

• The registrar calls the patient into the office, verifies the name and date of birth, has the patient sign the consent form, and walks the patient to the appointment location.

Here are some other changes the department made to satisfy patients:

• The hospital's insurance verification team explained terms such as "deductible" and "co-insurance" to registration staff.

"When the registrar or pre-registrar speaks with the patient about their coverage, they are able to clarify what the terms mean," says Brown.

If patients still are confused about their coverage, registrars reach out to their direct contacts in the financial counseling department. "They put patients as quickly as possible in touch with someone who can assist them further," says Brown.

It was difficult for registrars to get comfortable collecting in the first place, but this conversation has become much easier, says Brown. "Most patients want this information. We find now they expect it when they come in," she says.

• Patient access leaders listen to what staff members say to patients.

"We sit in on registrations," says Brown. "We then give feedback immediately to registrars as to what they did well and what they can improve upon."

• Registrars tell patients what they are doing, approximately how long the registration will take, and that the patient will be on time for their appointment.

"Registrars do what they can to ease the anxiety of what is happening, by openly communicating the process," says Brown. "The registrar

walks the patient to their appointment area, and the handoff is smooth." ■

# Patient not honest? Coverage unlikely

*Some might withhold information*

"Get out of my room! I'm not signing any paperwork. How you get paid is your problem, not mine." That's what a self-pay patient who required open heart surgery told a case manager at Trinity Rock Island (IL).

The employee was unable to determine if the patient was eligible for some type of assistance, because she refused to provide any information. The next day, **Linaka Kain**, the hospital's disability examiner and Medicaid specialist, turned things around with a direct approach.

"I told her, 'I want you to understand that this illness is chronic, and you will need follow-up care with specialists. How do you see yourself obtaining these things if doctors in private practice are not going to see you because you have no money?" says Kain.

Kain stated that her goal was to get the patient coverage, which would allow her to get the care she needed, not just right now at the hospital, but elsewhere as well. "I asked her to think about that, and then call me if she decided she wanted my help," she says. A few minutes later, the patient asked Kain to return. After learning that the woman was appealing a denial for Social Security Disability, Kain was able to provide her with documentation to assist in her appeal.

## More information

Job history, the fact that the patient declined employer-provided coverage, lack of a permanent address, or the details of temporary living arrangements are important factors that can determine how a patient can obtain coverage.

"Getting more information from the get-go enables you to tell where the patient is going to fall in terms of various kinds of programs," says Kain.

To get patients to be more forthcoming with information, Kain chooses her words carefully, using these practices:

**• Kain doesn't tell them her actual job title.**

If patients hear the words "disability examiner" or "Medicaid specialist," they might tune out right away. "They will say, 'Well, I'm not disabled," or "I'm not eligible for Medicaid.' Even if you say, 'I'm a financial counselor,' they think you are there to collect money, and they become defensive," she says.

Instead, Kain identifies herself as a "benefits administrator," which helps patients to understand that she's there to see if they're possibly eligible for some type of assistance program.

**• The first thing Kain says is, "I'm here to help you."**

"That breaks the ice right away," she says. "If you take that approach, they are more apt to give you the information that you are trying to obtain."

**• Kain avoids mentioning payment plans in the beginning of the conversation.**

"You don't want to seem like you are putting your hand out to get some type of payment," she says. However, if the patient appears uncooperative, Kain doesn't hesitate to ask how they plan to pay their out-of-pocket costs. "You can usually tell by their answer if they will be able to do a payment plan or if it's totally out of the question," says Kain.

**• Kain tries to get a whole picture of the patient's situation, including clinical concerns.**

If she learns a patient has a chronic or long-term condition, she uses this information to underscore why it's so important the patient needs to cooperate. "That opens the door to me saying, 'Even the assistance program we offer isn't going to take care of all your bills. You will need some type of insurance,'" she says.

**• Kain generally waits to meet with patients only after they're on the floor.**

When patients are in the intensive care unit, they are typically very sick and not as coherent or willing to talk, she says. "By waiting until they get up on the floor, it makes patients feel you are not thinking about money first and them second."

**• Kain asks if the patient is receiving any other kinds of assistance.**

"If you find out the patient is on food stamps, for example, you know they have already been screened as being below 200% of the [Federal Poverty Level]," says Kain. "This way, you are not duplicating efforts." ■

# Access can prevent some readmissions

Occasionally, a patient's name on the admission sheet jumps out at Linaka Kain, disability examiner/Medicaid specialist at Trinity Rock

Island (IL) campus, because she's seen it many times in a short amount of time.

"If the patient has been here 10 times in a month, that is a red flag, and we need to figure out what is going on," she says. Sometimes, a patient tells Kain, "You discharged me too early, and I got sick again," and she discovers that the patient is being readmitted so often due to non-compliance with their medications or treatment plan.

If this is happening because of lack of coverage, she says, "now is the time to get the patient on a program. A lot of people think, 'They'll just deny me.' I tell them, 'If someone is helping you that knows the process, you are more likely to get approved.'"

Some patients don't realize what they will need to go through after discharge, such as filling medications or obtaining follow-up care. "We can assist them with a week or two of vouchers for prescriptions. But if they don't continue that, they will end up right back in the hospital," says Kain.

Kain informs patients about a clinic they can go to at no cost if they are employed, which is staffed by volunteer nurses and physicians helping to provide care for employed persons without insurance. "The clinic can assist them in signing up for patient assistance through the drug companies and can help them establish a primary care physician if they don't have one already," she says.

Once patients have coverage, they often become more compliant with their treatment plan and stop getting readmitted so often, according to Kain. "They switch their way of thinking," she says. "In some cases, they don't use the ER as often. They have coverage, so they start going to the doctor instead." ■

# Stop morale in ED from plummeting

*Role `isn't for everyone'*

Your new hire's impressive experience with registration and financial counseling doesn't mean he or she is the right fit for the emergency department (ED).

The emergency department is a stressful place for registrars to work, says **Vicki Lyons**, patient access manager at Baptist Hospital East in Louisville, KY. "It is constantly busy, and involves dealing with sometimes very difficult situations, not to speak of difficult patients," Lyons says. "It takes a special person to work in the ER. It is not for everyone."

Weekend and holiday shifts are the hardest positions to fill, says **Nicole Marsoobian**, manager of admitting at Tufts Medical Center in Boston. "Those who are applying already have full-time jobs and just want to work part-time for extra money," she explains. "Once they get into the job, they give their notice after only a few months — usually because working seven days a week is too much, or they do not enjoy working holidays." Here are some proven approaches to keep ED registrars happy:

**• After Lyons interviews applicants for emergency department positions, she asks the applicant to "shadow" an experienced ED registrar.**

"We have a confidentiality agreement signed upfront before the applicant goes to the [ED]," she explains. By shadowing the experienced ED registrar, says Lyons, the applicant "can see exactly where they will be working, what they will be doing, and how hectic it can be."

Applicants watch about five patients being registered, including how insurance cards and drivers IDs are scanned, how a picture is taken, and what forms are signed.

Some applicants end up telling Lyons they no longer want the ED position because it's too hectic. "Others have not worked in healthcare before and do not like working that closely with sick people or the trauma of seeing family members upset about their loved ones," says Lyons.

**• Marsoobian ensures that everyone has a fair share of time off for holidays.**

"We came up with a holiday rotation calendar. All employees who work in the ED have to cover a couple of holidays a year," she says.

Weekend registrars are required to work non-major holidays, and Christmas, Thanksgiving,

## EXECUTIVE SUMMARY

Emergency department registrars must be able to handle a fast-paced environment, traumatized patients and family, sudden surges in patient volume, and occasional disrespectful attitudes from clinicians.

- Have prospective hires "shadow" registrars in the department.
- Educate clinicians on the importance of the registrar's role.
- Ensure adequate coverage so staff members aren't overwhelmed.

the Fourth of July, and New Year's Day are split among all ED registrars.

**• Lyons uses "floater" positions to ensure ED registrars aren't overwhelmed by sudden increases in patient volume.**

Each day, some of Baptist Hospital East's patient access employees are designated as "floaters" and might be pulled to the ED to help out during weekends or during volume surges until staff are caught up.

"We have another employee that relieves employees for lunch breaks so that there are always three employees in the ER," says Lyons. "The ER staff know they can call for help if they get a big influx of patients."

The floater positions have improved turnover in the ED registration area, because registrars now have to work only one weekend a month or sometimes no weekends at all, says Lyons. "The ER could not manage with just two employees working," she explains. "If we are short and do not have floaters available, we pull someone from another area, or have a trainer, lead, or supervisor work in the ER."

### SOURCES

For more information on improving morale of emergency department registrars, contact:
• **Vicki Lyons**, Patient Access Manager, Baptist Hospital East, Louisville, KY. Phone: (502) 897-8159. E-mail: Vlyons@BHSI.com.
• **Nicole Marsoobian**, Manager, Admitting, Tufts Medical Center, Boston. Phone: (617) 636-2271. Fax: (617) 636-1046. Email: nmarsoobian@tuftsmedicalcenter.org. ■

# A simple audit can correct dissatisfiers

*Staff average 90% or better*

Do staff members mention a patient's name — not just once, but three times — during the registration process? This step is something that all patient access employees are expected to do at St. Anthony Hospital in Lakewood, CO, says **Tammy Casados**, manager of patient access.

Patient access associates are required to complete the Studer Group's AIDET Five Fundamentals of Patient Communication course within the first 30 days of employment and annually as a refresher course. *(For more information, see resource box, p. 31.)* The course requires staff members to do the following:

• **Acknowledge** the patient.
• **Introduce** themselves.
• Tell the patient how long the **duration** of registration will be.
• **Explain** the registration process, any necessary forms that need to be completed, collections of any amount due, and any delays. For example, staff may tell a patient, "We are waiting for your room assignment," or "X-ray is running a little behind today, but we will keep you informed of any longer delays."
• **Thank** the patient and ask, "Is there anything else I can assist you with today?"

"This is how we build trust and communication with our customer, who may be feeling a little nervous, anxious, or vulnerable for their visit at our facility," says Casados.

## HCAHPS score is goal

In February 2012, the department implemented a First Impression Team and a monthly audit in outpatient registration areas, with the goal to improve its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score, which is publicly reported by the Centers for Medicare & Medicaid on the Hospital Compare website (www.hospitalcompare.hhs.gov).

Managers complete an audit form on whether staff took action steps during an observed patient encounter, such as standing up from their desk to greet the patient. Staff average 90% or better on the audits. "We view the registrar and listen to their conversation with the patient and family," says Casados. "After the patient is escorted to their procedure, we talk with the registrar on what we viewed." *(See list of actions managers look for when auditing outpatient locations, p. 31.)*


## EXECUTIVE SUMMARY

Patient access employees at St. Anthony Hospital in Lakewood, CO, are audited by managers checking for specific customer-friendly practices, and a group of patient access staff is charged with coming up with ideas to improve service.
• Staff members mention a patient's name at least three times.
• Staff members incorporate personal comments into conversations.
• Managers give real-time feedback.

Recently, a new registrar in the hospital's main lobby scored a disappointing 55% out of 100% on the audit. Casados told her immediately afterward that she didn't complete a personal touch with the patient, she only used the patient's name twice, and she didn't stand up to greet the patient. Casados reviewed the list of action steps to follow.

"The next time I completed an audit on her, she was sitting down when the patient walked into the office," says Casados. "All of a sudden, she jumped up, extended her hand and gave her name. It was like a light bulb went off."

The registrar got 100% score on the audit, and the patient left her office looking relaxed while they talked about the upcoming Bronco game.

At first, staff found it difficult to use the patient's name at least three times, but there are many ways to fit this into the conversation, says Casados. For example, staff might say, "Mary, how is your day going so far?" "Mary, that's a beautiful necklace," and use the patient's name again when going over the forms to sign.

"They now find it very easy to do this, once they find out how they patient wants to be addressed," she says. *(See related story, right, on a group of patient access employees charged with improving service.)*

**SOURCE/RESOURCE**

For more information on auditing patient access employees, contact:

• **Tammy Casados**, CHAM, Manager, Patient Access, St. Anthony Hospital, Lakewood, CO. Phone: (720) 321-0428. Fax: (720) 321-0430. Email: TammyCasados@Centura.org.

• The **AIDET Five Fundamentals of Patient Communication** is a video-based training resource that trains leaders to reduce patient anxiety, improve patient compliance, improve clinical outcomes, and increase patient satisfaction. The cost, which includes a 2-hour DVD, implementation guide, 50 participant guides, and 50 pocket cards, is $2,150 plus shipping. For more information, contact Fire Starter Publishing, Gulf Breeze, FL. Phone: (866) 354-3473. Fax: (850) 916-3532. Email: info@firestarterpublishing.com. Web: www.FireStarterPublishing.com. ■

# Audit staff members for these 5 things

Patient access managers at St. Anthony Hospital in Lakewood, CO, audit all registrars at each outpatient location monthly, and expect a score of 90 points or higher, says Tammy Casados, CHAM, manager of patient access. They check for these five things:

1. Did the registrar stand up when the patient presented themselves? (Yes = 20 points, no = 0 points)
2. Did the registrar introduce themselves to the patient? (Yes = 20 points, no = 0 points)
3. Did the registrar use the patient's preferred name at least three times during the registration process? What name was used for the patient? (Once = 5 points, twice = an additional 5 points, three times = an additional 5 points)
4. Did the registrar use a personal touch in the conversation? What was the personal touch? (For example, "How is your day going?" "That is a very pretty scarf," "I was born in Minnesota as well.") (Yes = 20 points, no = 0 points)
5. Did the registrar end the conversation by saying "Is there anything else I can do for you?" (Yes = 20 points, no = 0 points) ■

# Group of access staff boost patient satisfaction

A small group of patient access employees at St. Anthony Central in Lakewood, CO, participate in the department's "Unit Base Council" which is charged with coming up with ways to improve customer satisfaction.

"An email was sent out to the patient access team to see who would like to sit on the council," says **Tammy Casados**, manager of patient access. The council now has five members from patient access registration, three financial counselors, and one member from central scheduling. Each member was given the book "Coaching for Improved Work Performance: How to Get Better Results from Your Employees" (McGraw-Hill, 2000) to read.

For its first meeting in September 2012, the group assigned the roles of chair, recorder, and facilitator. "At this time, the group is meeting bi-monthly to get established. We will then look at going to once-a-month meetings." So far, the group has come up with these ideas:

• **They decided to have schedulers visit provider's offices for a "meet and greet."**

The scheduling office already has visited one physician office to review the hospital's scheduling process and to answer any questions the office staff had, says Casados.

**• They started developing a job shadowing program for registration, financial counseling, and scheduling.**

"They want each area to know the process of each area's job responsibilities," says Casados. For example, a scheduler recently spent some time working with an emergency department (ED) registrar to see how information is collected from the patient and realized how quickly registrars need to complete their work during sudden volume surges. The schedule saw that it wasn't always possible to collect all the necessary data at the beginning of a registration and that it sometimes takes several attempts to get the account updated, adds Casados.

**• They suggested improving the way volunteers are trained.**

"We have given them access to our pre-registration and scheduled visit information, which can be run at any time during the day," says Casados. "With this information, they can send the patient direct to the department of service."

If volunteers see a patient in a "scheduled" status, they now know the patient needs to go to the patient registration are to check in, for example.

**• They agreed to send a survey to other departments to ask for input on how to improve the registration process.**

**• They decided to add an "after hours" phone for ED registration.**

Previously, there was signage instructing patients to call the operator when no volunteer was present in the main lobby, but the council decided it would be more customer-friendly for patients to talk directly with an ED registrar if they needed to check in after hours.

"It was approved to put new signage and an after-hours phone that will go direct to ER registration," says Casados. "The patient or family can pick up and be connected immediately with our ER registration area for assistance." ■

# New webportal gives much info to patients

*Patients can do a lot before they arrive*

The University of Texas M.D. Anderson Cancer Center in Houston launched a new patient webportal that allows patients to participate in scheduling their first appointment, reports **Connie Longuet**, MBA, MHA, CHAM, director of patient access services.

The hospital had a webportal in place for years for patients who already had been to the hospital, but a potential new patient's communication was done completely through telephone calls. "When a patient contacts us to schedule their first appointment, they can now go online and complete a request form," says Longuet.

The patient can choose to enter basic contact information and request that someone call them back, but about 65% choose to continue online and complete additional demographic and medical information forms. "This allows patients to have time to compile the needed data, including current medications, previous treatments, and family history," says Longuet. When this information is gathered over the phone, it often takes several phone calls for patient access staff to convey what is needed and more calls to for the patient to provide the information to the hospital.

"We provided callers with lots of information: where to park, lodging, what to bring, and when their appointment was," says Longuet. Patients are now able to get this information online, as well as:

• Set up preference options that allow them to receive email and text notifications during different steps in the process. "Staff can send an email or text to a patient when they need to reach them and have not been able to by phone," adds Longuet.

• See if the hospital has received medical records, pathology reports, or diagnostic reports.

• View and print an insurance summary page of their benefits, including co-pays, deductibles, co-insurance, pre-existing clauses, and lifetime maximums.

The new web portal was implemented in five

## EXECUTIVE SUMMARY

A newly launched webportal allows patients at University of Texas M.D. Anderson Cancer Center in Houston to view appointments, complete patient history forms, and review consents online before arriving.

• About 65% of patients choose to complete information online.

• Patient access staff spend less time providing information to callers.

• A web chat feature soon will be added.

clinics, and the remaining clinics are being rolled out by August 2013.

"It has taken tremendous coordination between our Internet services technical team, the technical team that manages our patient master files, and patient access services," says Longuet. The biggest challenge, she says, is to ensure data is transmitted in a timely manner and patients are viewing the most up-do-date information.

### Next step: Web chat feature

In phase two of the project, the organization will add a web chat feature that will allow patients to ask a question with a live representative during normal business hours.

"The patient always has the option to speak to us by phone as well," says Longuet. "But with current technology, there are many other options. We want to offer choices to our patients."

#### SOURCE

For more information on patient web portals in patient access, contact:

• **Connie Longuet**, MBA, MHA, CHAM, Director, Patient Access Services, The University of Texas M.D. Anderson Cancer Center, Houston. E-mail: clonguet@mdanderson.org. ■

# Demand respect for patient access staff

*Clinicians need educating on role*

If a registrar is in the middle of collecting demographic information from a patient, he or she might be suddenly interrupted by a clinician entering the room.

At times, the clinician begins talking with the patient as though no one else is in the room, according to Jacque Hess, manager of patient access of OSF Healthcare in Peoria, IL.

"Registrars then back out of the room and try to come back to the room before the patient leaves the department," she explains. "Registrars then feel embarrassed and frustrated."

Hess says clinicians sometimes have difficulty understanding that registrars also play a very important role. "Registrars, at times, feel as though the clinical staff think the registrars have to automatically stop and leave the room when a doctor or nurse enters a patient's room, no matter where they are in their process," says Hess.

While most clinical staff members make registrars feel part of the team, "at times, registrars come across some clinical staff that make them feel less important," she says. Registrars understand that there are times that they need to leave the room right away and make an attempt to finish their process later, says Hess, but clinicians don't always respond in kind by allowing registrars to do their jobs.

"No one is trying to be rude or trying to make anyone feel like they are not worthy," says Hess. "But I believe that an explanation of why everyone is important, when the new clinical staff are hired, would help." Hess takes these steps to educate clinicians and registrars on the need to work as a team:

- Hess instructs her registration staff to tell the clinical staff where they are in the registration, stating, "I'm almost finished. It will just be a few more minutes."
- If the clinical staff members allow the registrar to stay in the room, she tells them to make sure to say, "Thank you. It really helped for me to stay and finish the process."
- If the registrars are having difficulty completing the process, Hess asks the manager to share that with clinical staff in department meetings.

"The registrars are included in every way, to make them feel part of the team," she says. "I see improvement every day with the teamwork of the staff."

### Registrars, patients happier

At Mercy Medical Center in Oshkosh, WI, customer service scores in the emergency department increased by 30% after a new registration process was implemented, based on feedback given from clinicians and registrars.

There previously was a feeling that registrars and clinicians were at odds with one another, according to Linda Swanson, registration coordinator.

"We used to have the situation of 'the ER department against the registration department.' The walls were there," she says. "To help knock those down, we needed manager assistance from both areas."

Swanson found that both areas lacked understanding about what the other did, and both areas now ask clinicians and registrars to work alongside one another and observe what they do. "One of the neat things was we built a friend-

ship between each department, and it's still going strong," says Swanson. "We all help one another." Swanson also involved clinical and registration staff to determine the best process for registration from arrival until discharge.

"We literally took a few staff from each area, sat down for three days, presented the current process, and started fresh," she says. The group discussed what they would want if they were patients and what patients complained about most regarding registration.

"We came up with a great process, which we then promoted to the rest of the staff of the two departments," says Swanson. "We turned around the negativity, and our customer service scores have soared!" This is the new process used by emergency department registrars and clinicians:

- Registrars complete a "short-form" registration, meaning they just ask for the patient's name, date of birth, primary care physician and chief complaint, and enter this information into the computer system to generate an account number.
- The patient is entered into the ED electronic record system, which alerts nurses that a new patient is logged in.
- Registrars call for the patient to be taken to a bed, or if the situation is emergent, they bring the patient immediately back without calling.
- The primary or triage nurse takes the patient's vital signs, the emergency physician sees the patient, and the patient obtains laboratory and diagnostic tests as needed.

"We come to the bedside to do the registration and consents about 20 minutes after the doctor has been in to see the patient," says Swanson. "We found that patients do not want to wait once they are discharged to do paperwork. Many would leave if you were not available or with another patient."

The new process ensures compliance with the Emergency Medical Treatment & Labor Act (EMTALA), and ensures that registrars see the patients during breaks in the treatment process. "Patients like going directly to a bed, versus being triaged at a separate area and then taken to a bed. Rooming right away was key, as was having us come in later on," says Swanson. "Our rate for patients that leave without seeing a registrar went down from 25 to one or two a month."

**SOURCES**

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# Public hospitals seek input from patients

A growing number of public hospitals are engaging their patients in a conversation on how to improve service, according to the National Association of Healthcare Access Management (NAHAM), which refers to a story in "Modern Healthcare." New committees and boards have been set up across the country, with membership comprised of patients or patients' families. These committees seek the voice and the view of the patient as it relates to how care is delivered within the hospital. The timing for this trend is not by accident.

Patient input and satisfaction have come back into the spotlight due to incentive programs recently put in place by the federal government. The Affordable Care Act carried with it both stick and carrot approaches to encourage hospitals and other patient care facilities to place patient care first.

The new Medicare Value Based Purchasing Program serves as the stick. The program focuses on the whole of patient care, including patient readmissions, shifting away from the traditional fee for service reimbursement model. Hospitals can lose from 1-3% of federal reimbursements for high readmission numbers.

The carrot, on the other hand, comes in the form of an electronic health record (EHR) incentive program that rewards hospitals for using the new technology. The program is still in its first stage, focusing on raw implementation of EHR systems, but the second stage will focus on meaningful use of the records. The program mandates that EHR technology must provide patients with an online means to view, download, and transmit selected data. More information on the EHR Incentive Program can be found at http://go.cms.gov/OWhNS1.

The Gordon and Berry Moore Foundation is also providing a carrot with its Patient Care Program. The program works toward eliminating patient harm with a two-pronged approach. They emphasize meaningful patient and family

engagement, and a re-engineering of hospital processes. In turn, they believe that healthcare will become more cost effective and be more respectful to the patients and families they serve. To work toward the goal, they are planning to give out $500 million in grants to hospitals willing to alter their patient care model.

Ideas that come from these patient committees or boards can provide simple and effective ideas for hospitals. A hospital in northern California had a logical policy that all emergency patients had to be funneled through the emergency department. This process included psychiatric patients who would be forced to have psychiatric episodes in the general ED. It was not until the hospital listened to advocacy from the mother of a mental health patient that the policy was changed to allow direct access to the psychiatric emergency department. This simple shift restored a sense of dignity and respect to an entire group of patients.

Another hospital in Oakland, CA, was shocked to hear about issues that patients experience when working with multiple hospital units. In this instance, physician rounds at 2 p.m. meant that a nurse wouldn't order a prescription until 2:30, which left little time for a patient to fill it in the discharge pharmacy before it closed at 3 p.m. This schedule might delay a discharge and prevent another patient from getting an inpatient bed.

Still, other hospitals are requiring staff to attend patient care events that include patient panels and best practice discussions.

The original article from "Modern Healthcare" is available at http://bit.ly/YOd0cZ. ■

# Study shows copying common in EHR notes

Electronic health records (EHRs) have long been touted as a transformative tool in medicine. The data can be shared easily between the patient and medical staff, medications can be automatically screened to ensure safety, and a doctor's scribbles can be changed to easily read text. All of this good, however, is dependent upon the information in the EHR being accurate, reports the National Association of Healthcare Access Management.

Many EHR systems allow users to copy and paste information, and according to one study, this step can cause information to be incorrect or outdated. The study, done by a team at Case Western Reserve University School of Medicine, examined 2,068 progress reports for 135 patients in the ICU of a Cleveland hospital. The reports were created by 62 residents and 11 attending physicians, and they were monitored over five months using plagiarism detection software. *(To access the study, published in "Critical Care Medicine," go to http://bit.ly/Tp1f8j. To access the Reuters article about the study, go to http://reut.rs/UEz6KB.)*

The team found that in 82% of the notes made by the residents and 74% of the notes made by attending physicians, 20% or more of the text was copied and pasted from preexisting text from the patient's records. These reports are used by internal hospital staff to monitor patient progress, but text containing a significant amount of pasted information might not be helpful. In one case, doctors of a patient who was released and then readmitted to the ICU couldn't understand the previous progress reports. The pasted notes gave no clues as to the original diagnosis, and the new doctors had to call the diagnosing physician.

This study could signal that doctors are using notes as more of a method to document billing then as a method to communicate with other healthcare staff. ■

# 2013 provisions for healthcare reform

A new year means new provisions to be put in in place under the Affordable Care Act, the National Association of Healthcare Access Management reports.

## COMING IN FUTURE MONTHS

- Share rave reviews on access with hospital leaders
- Take action based on patient and family feedback
- Educate clinical areas about revenue cycle
- Aggressively monitor productivity of registrars

There are four provisions slated to go into effect this year, and three of them went into effect in January.

The first provision provides new funding to state Medicaid programs that choose to cover preventative services for patients at little or no cost. The program provides states with a 1 percentage point increase in federal matching payments to provide these services.

Another provision requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government and is a ramp up to Medicaid providers serving more patients in 2014.

The final provision that was effective on New Year's Day establishes a national pilot program on payment "bundling." Under payment bundling, hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system in which each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver healthcare services more efficiently while maintaining or improving quality of care.

Under a fourth provision of the Affordable Care Act, effective on Oct. 1, 2013, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. This is provided under the existing Children's Health Insurance Program (CHIP) plan.

Also, open enrollment for state health insurance exchanges will begin this year for coverage beginning on Jan. 1, 2014. ■

# Did you receive our ebulletin?

"Hospital Access Management" readers were sent an e-bulletin on Jan. 25 about new research analyzing the cost of prior authorizations to physician offices and what this study means for patient access. If you didn't receive it, that means we don't have your email address. Contact customer service at (800) 688-2421 or send an email to customerservice@ahcmedia.com. ■