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AHC Media

Does `C suite' undervalue access? Don't be shy about your successes!

Reinforce the importance of patient access

"What information do you need that you are not getting today, in order to be successful in your job?"

Amber Reeff, director of patient access systems at Virginia Mason Medical Center in Seattle, routinely asks hospital leaders this question. "It's amazing how many people will grab onto that rope when you throw it to them," she says. "Sometimes people don't see the connection right away. They see patient access as another entity, when in fact, we are an extension of the care team."

One thing Reeff learned was that senior leaders wanted more data on the barriers to care that patients experienced. "They wanted to know how many patients aren't able to get through our door, and why," she says. To answer this question, Reeff surveyed a group of schedulers, and asked them to identify the top three barriers to getting a patient scheduled, and shared her findings with senior leaders.

"It is critical to communicate the health of our front door to all senior leaders, and any barriers or challenges that may exist," says Reeff. "If you can't get patients through your front door, you are not going to be viable."

Hospital leaders often don't realize the sheer volume of information collected by admitting staff, and don't need to know all the details of what patient access does, says Reeff, but they do need to trust the information they are receiving.

EXECUTIVE SUMMARY

Front-end processes are getting increasing attention from hospital administrators. Patient access leaders need key performance indicators to "tell the story" of their department.

- Ask hospital leaders what information they need that they aren't receiving,
- Base staffing models on patient flow to show your department operates in a clinical operations capacity.
- Demonstrate that patient access contributes to increased volumes in clinical areas.

"It is our responsibility as patient access leaders to ensure senior leaders have the most current information to guide them in making an informed business decision," she says. "There is so much hidden treasure in these areas, and it doesn't require expensive technology or a complex process of data gathering. It lies in the staff who are manning your front door."

Patient access is often undervalued, but this situation is changing as the complexity of the position continues to evolve, according to **Stacy Calvaruso**, CHAM, assistant vice president of patient management at Ochsner Health System in New Orleans. "We are now seeing progressive organizations strive for better metrics on front-end performance," Calvaruso says. "Shine the light on the shift from back-end processing to front-end processing. The analytics will 'toot the horns' of top-performing facilities!"

Show KPIs to leaders

With so many different areas of focus in health care today, being able to communicate "well and appropriately" to senior leaders is necessary to reinforce the importance of patient access, emphasizes **Courtney M. Higdon**, director of Enterprise Patient Access Services at UK HealthCare in Lexington, KY.

"VIPs do have limited time," says Higdon. "That is why it is important to be able to 'tell the story' of patient access for the organization in a few key performance metrics and graphics."

Calvaruso says these key performance indicators (KPIs) are essential to show leaders how front-end processes affect hospital operations and the revenue cycle:

— average registration time;

— point-of-service collections, compared to the amounts available to collect;

— the number of patients who leave the emergency department without being seen;

— in-house authorizations pending;

— discharged not final billed, related to registration and admitting;

— department productivity;

— patient access-related denials;

— overall quality assurance (QA) scores.

Each facility at Ochsner has its own KPI scorecard. "At the end of the month, we roll this up into a patient access dashboard," says Calvaruso. "We distribute it to our CFOs, senior leaders, and key operational business partners."

Hospital leaders especially appreciate the dashboard because it gives them a high-level view that allows them to drill down into any area they have a concern with, she adds. Here are ways in which patient access leaders can attract the attention of senior leaders:

• Create dashboards to track important data, and periodically share those results.

"Produce measurable results in important areas such as point-of-service collections and patient satisfaction," advises Higdon.

• Keep leaders informed of instances of outstanding individual performance from registrars.

"This allows the employee to be recognized at the highest levels of the organization and the leader to be more closely engaged in the role of the department in the organization," Higdon says.

• Tie results to revenue cycle KPIs.

For example, if your QA scores are showing 98% accuracy but the claims are being denied, determine

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how this could be possible. "Are your claim scrubber rules too stringent? Do you not have the correct rules in your front-end QA process?" asks Calvaruso.

By demonstrating that the front end is aware of, and is monitoring, the claim scrubber pass/fail rate as well as the denial rates, you'll be able to articulate to administrative leaders "the fact that it all really does start at the front end," Calvaruso says.

• Help executive team members to view the front-end teams as an operational department as opposed to a revenue cycle department.

"Registration is 24/7, which is staffed mostly based on visit volumes and patient flow. Clinical operations staffing models are the same," Calvaruso explains. By reinforcing that patient access operates in a clinical operations capacity, executive leaders will be able to tie department outcomes to operational performance, she says. One way to do this is to base staffing models on patient flow, instead of using a flat staffing level.

"By tying your KPIs to operational processes, you can paint a better picture of potential opportunities," adds Calvaruso.

• Make others aware that patient access plays a role in increased volume.

"Many times, the front desk is forgotten when we congratulate certain areas or departments on having such a high volume month," says Calvaruso. She says it's the job of patient access leaders to counter this perception.

"If the collaborative relationship is strong enough, everyone realizes that increased volumes are directly related to the patients getting scheduled and registered for those services, which is performed by the front desk," she says. (*See related story on how patient access leaders at Virginia Mason Medical Center interact with hospital leaders, below.)* ■

You should connect with hospital leaders

Patient access leaders at Virginia Mason Medical Center in Seattle "have a seat at so many different tables in the organization," reports **Amber Reeff**, director of patient access systems. "This gives us the opportunity to brainstorm with various leaders, both as part of the planning process and 'in-the-moment' huddles."

Here are ways that patient access leaders interact with senior leaders at the organization:

• Senior leaders make rounds throughout the organization, including registration areas, to view production boards.

Kristi Hoagland, manager of revenue stream and admitting, says, "Anyone can come into our workspaces and see our metrics and activities. We use dashboards that are color-coded red, yellow, and green. Things get expedited very fast if there are any concerns."

• A patient safety alert (PSA) system is used if any issues arise that potentially could compromise care.

The term "patient safety" makes most people think about something that is strictly clinical, says Hoagland, but patient access areas use these to report any issue that needs attention.

"Our safety office assigns a severity level which invokes different levels of leadership, which ensures immediate attention from hospital leaders as appropriate," says Hoagland. For example, a PSA was filed when a registrar created two visits, which potentially could cause a problem for the care team.

• Patient access is directly involved in identifying possible obstacles to the admissions process.

The hospital's admissions center uses an "admissions viewer" report, which makes the admission process transparent and accessible to all hospital leaders. It shows exactly where a patient is in the process. "For example, it may be that we are waiting for the ED nurse to call us back with a final report, or that the patient is unstable for transport," Hoagland says. "In some cases, we need to do an 'intake huddle' to address a situation right away."

• When the hospital is determining whether a particular patient needs to be admitted, patient access staff provide information on the patient's financial situation.

Patient access staff work with a physician advisor, a utilization review nurse manager, a charity manager and a financial counselor manager to ensure every patient that needs help gets it, says Hoagland. "We are right at the table for every patient coming into the hospital," she says. "We contribute information to build the entire patient story, which includes clinical, social and financial components, to determine what is the right thing for that patient." ■

Give registrars a way to move up!

Employees expect chance to advance

"There is nowhere to go when you are in patient access." This is the number one complaint that **Jennifer White,** director of patient access at Cottage

Hospital in Woodsville NH, hears from her registrars.

Patient access employees are working alongside other departments with more growth opportunities, better schedules, and more pay, says White.

There are often opportunities for paid training in clinical areas. "This can easily pick off your most motivated coworkers," says **Kim Crouse**, CHAM, education specialist for patient access at Mercy Hospital Springfield (MO). "New coworkers come from a generation of immediate gratification. If they don't find movement available within a year, they are likely to start seeking other places to work." Here are some ways to create a sense of "movement" in patient access:

• Cross-train employees.

"By setting goals for development, the coworker has the opportunity to accomplish more than just basic access functions," says Crouse. "They have something they can achieve that is not dependent upon someone else vacating a position."

Crouse has cross-trained employees in different areas of patient access to help expand their knowledge of processes and functions. Staff members appreciate working in various areas, so they're not doing the same thing every day. "This has kept them engaged in patient access. It has the added benefit of increasing productivity and helping the coworker advance," she says.

• Create a "step-up" position from the basic entry-level role.

Mercy Hospital Springfield has a few senior patient access representative positions, and leaders are considering adding additional positions.

"Such positions can be tied to tenure and performance – two critical pieces to organizational success," says **Michael Spence**, MBA, financial analyst for patient access at Mercy Hospital Springfield. "This creates the challenge many coworkers need to feel accomplished."

Actively seek out the untapped potential of patient access employees, and provide some opportunities to use that potential, advises Spence. A registrar who is great with the technical aspects of the role could be challenged to work some more complex issues out of work queues, for example, whereas a registrar with top-notch interpersonal skills could be tapped as a mentor to less seasoned coworkers. Here are some ways Spence has found to use "untapped potential" of patient access employees:

• Several Internet-savvy employees are performing insurance verification.

• Employees who handle admission room update took on more of the registration process and ultimately were promoted.

• Experienced employees are asked to train and mentor newly hired employees.

Money often issue

"I try to be aware of staff who may not be happy by looking for different clues such as attitude and work quality," says White. "I try to cut the resignation off at the pass, so to speak."

At times, however, experienced registrars have left patient access for other areas of the hospital due solely to increased salary. White says she doesn't believe managers should play the "money game" with staff. "As much as I would prefer not to go through the interview and new hire process, I will not stand in my staff's way if it is something that is a benefit to them or their family," she says.

However, in some cases, new tasks and responsibilities have convinced staff at Cottage Hospital to stay in patient access. A newly implemented registration ladder offers growth and promotion within the department, with five "rungs. These are Registrar I, Registrar II, Registrar III, Registrar IV, and Patient Access Supervisor, which can be filled by only one employee. Registrars apply for the next level at their annual reviews. "Each rung has a monetary value associated with it," she says. "Each level starts out with the same criteria, but as you move up the accuracy percentage changes, and you are required to volunteer more, with increased job responsibility."

For example, a Registrar III is required to maintain a 95% accuracy rate and be cross-trained to cover three hospital departments. For a registrar to meet the criteria for a Registrar IV, those requirements increase to 96% and four or more departments.

White worked on the registration ladder for two years. She began by soliciting feedback from the staff so they would feel as though they were a part of the new process. "I then submitted it to my senior representative, and after draft revisions, submitted it to HR for final approval," White says. "We are in the implementation phase now. Staff are very appreciative to be recognized for their level of accomplishment within their department." [*A copy of the*

EXECUTIVE SUMMARY

Lack of opportunity for advancement is a common reason for registrars leaving patient access for other areas of the hospital. • Cross train staff in different areas of patient access.

• Create a "step-up" position.

• Ask employees to train and mentor new hires.

registration ladder is available with the online issue. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]

SOURCES

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• **Jennifer White**, Director of Patient Access, Cottage Hospital, Woodsville NH. Phone: (603) 747-9252. Email: jawhite@cottagehospital.org. ■

Correct reg errors with real-time QA

Inaccurate demographic information at registration occurs for many reasons, but is the mistake fixed before the claim goes out the door? Or is it discovered months later, when the claim has been denied and the patient has received a bill?

"Our biggest challenge with improving accuracy is giving quick feedback on errors so they can be corrected in real-time," says **Nikki Taylor**, CPAR, assistant director of patient access services and patient accounts at Georgia Regents Medical Center in Augusta.

The department invested in a real-time quality assurance system, which flags inaccuracies on an account at the time of registration, such as incorrect characters in an insurance ID, the wrong amount of characters for a Medicare number, invalid patient address format, missing required information on the registration, and minors registered as their own guarantor.

"This helped each registrar be more accountable for their own errors at the time of working the account, as opposed to getting feedback potentially months later," says Taylor.

The system runs reports on each registrar and the error they did not correct. "Management can see who is truly working their errors timely," says Taylor.

Previously, managers discussed registration errors with employees only in a general sense. "We would sit in staff meetings and say we were receiving complaints from another area, indicating we had errors on accounts," says Taylor. Now, statistics and feedback goes out to each registrar on a weekly basis. "Until staff see the error for themselves and can make their own corrections, it is hard to change a pattern or learned behavior," says Taylor.

Managers hold quick monthly meetings with each staff to show errors that have occurred throughout the month.

"Each area is assigned to work specific root cause denials on the monthly reports," says Taylor. "We check for trends, issues, and miscommunications."

Managers also review accounts in which patients have called customer service with questions on accounts that could have been avoided if mistakes were fixed at registration.

Monthly denial meetings are held, with patient accounting, outpatient clinic registration staff, utilization management, and registration staff for day surgeries, observation and inpatient stays. "We pull denials specifically related to registration errors to review with staff," says Taylor.

Continual monitoring

At the Patient Accounts and Access Center at OSF Healthcare in Peoria, IL, the computer system places accounts into work queues if any piece of information is missing that is necessary to send out a bill.

"We have several work queues for each area of our hospital. The staff that work in those prospective areas fix whatever needs to be corrected on the account," says **Jacqueline Doerman**, MBA, patient access services manager of offsite registration. "If those accounts do not get fixed or need additional information, they go to our designated work queue specialists to work."

Patient access managers continually monitor work queues that hold accounts with missing information or rejected insurance. "Our staff and management team work them consistently, and our two work queue specialists work on them all day long," says Doerman.

The specialists and patient access managers share information on anything that was not done correctly, such as plan codes that were billed inaccurately, addresses in the wrong format, and claim information that was not filled out accurately.

"We are then able to take that feedback, and

EXECUTIVE SUMMARY

If registrars correct mistakes in real time, these can be fixed before the claim goes out the door, which prevents costly claims denials.
• Invest in a quality assurance system to flag inaccuracies at the time of registration.
• Require staff to continually correct their own errors.
• Review denied claims with errors that should have been corrected at registration.

present it to our staff," says Doerman. *(See related story on training to improve accuracy, below.)* ■

Want better accuracy? Training's the answer

Inaccurate demographic information can sometimes occur because patients aren't truthful or because they don't have certain pieces of information with them at registration.

However, more commonly, errors result because members of the patient access staff fail to follow the correct process, according to **Jacqueline Doerman,** MBA, patient access services manager of offsite registration at OSF Saint Francis Medical Center in Peoria, IL.

"To improve this, I have tried real-time coaching, auditing accounts, and analyzing our feedback surveys that patient fill out," says Doerman. "This has been helpful, but has not resolved the problem in all staff members."

Staff members don't always ask all of the questions that are necessary for a complete registration. "As a result, there are accounts that come back incomplete or inaccurate," she says. Here are some solutions Doerman uses:

• She gave a presentation to staff to show why it's necessary to enter each piece of information into the computer system and how this information affects billing.

Staff members enjoyed the presentation. "It helped them to see why they were doing certain things and how crucial it really was to complete that information," Doerman says. "When staff do things day in and day out, it becomes monotonous. They don't really even know why they are asking certain questions."

Registrars realized that everything they enter into the computer system has value. "They were able to connect the dots and see that is should not only be completed, but completed accurately," says Doerman.

• Managers give staff yearly competencies to be sure that they are following the correct process.

The competencies cover customer service as well as asking the correct questions, transcribing and scheduling patients accurately, collecting co-payments, and scanning documents. "During competencies, staff will ask process questions if they are unsure about certain things," adds Doerman.

• Managers observe employees registering patients.

"If we notice something is being done incorrectly, we are able to coach staff real-time," says Doerman. During observation, Doerman noticed that staff members sometimes were "feeding" the patients registration information instead of obtaining it from the patient, such as saying, "Do you still live at 123 Main St.?" instead of saying "Could you please verify your address for me?"

"We have concern for identity theft, as well as patients not accurately listening to what we are stating and verifying the incorrect information simply because they weren't listening attentively," she says. ■

Get uninsured to help themselves

Patients often have no idea they qualify

As a safety net hospital, Parkland Health & Hospital System in Dallas always has served the uninsured, and patient access employees have helped countless individuals to qualify for Medicaid, disability, grants, crime victims, or the hospital's charity program. Recently, however, they have worked with many patients who have never sought any type of assistance before.

"In the last two to three years, we have seen numbers of the formerly employed grow," reports **Robert Reed**, vice president of patient access/patient financial services administration. "We are seeing more people who are not your typical charity patients. They have lost their jobs and exhausted their unemployment, and are ill and need help."

Patient access employees review about 9,000 applications every month, and they help 65% of the hospital's patients obtain charity care and/or Medicaid coverage. An increasing number of these are employed individuals who can't afford to purchase insurance. "We also screen them for any other benefits they may be eligible for," Reed says.

Many uninsured patients are surprised at what programs they qualify for. For example, undocumented patients don't realize they're entitled to Medicaid coverage for emergency care.

"We dually screen them, both to reimburse us for that emergency, and also for our charity program to help them with medications, appointments, and follow-up care that may not be covered under Medicaid," says Reed. Crime victims often are surprised to learn they're eligible for a program that not only helps with medical bills, but also counseling and lost wages.

"Our patients are eligible for a multitude of programs, grants, disability, or any combination of

EXECUTIVE SUMMARY

Uninsured patients often qualify for assistance from hospital, state, or federal programs, but patients must cooperate with patient access employees to obtain coverage.

- Tell patients about all assistance programs for which they're possibly eligible.
- Make newly eligible Medicaid patients aware they can obtain follow-up care.
- Submit required documents for patients.

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those," says Reed. "Our goal is to screen them for any or all programs. We try to get it all done upfront, so it does not slow them down."

Once patients are covered by Medicaid, members of the patient access staff make them aware they can now make their follow-up appointments, obtain diagnostic tests, have prescriptions filled, and see a primary care physician. "If we can treat them before they become critically ill, they will stay out of the ED," says Reed.

Parkland's Transitional Care Unit strives to prevent readmissions in pneumonia, congestive heart failure, and myocardial infarction patients. "We are trying to target that population and get them to follow up on their treatment plan as they are supposed to," says Reed. "We expedite getting them whatever coverage we can, so there is no lapse in their care." Here are some obstacles that occur:

• Patients sometimes become defensive.

At times, patients hear the words "patient financial services" and assume the worst: that employees are there solely to collect large sums of money they simply don't have.

To counter this perception, members of the patient access staff tell patients that they're there to help them apply for any benefits that they might be entitled to. Next, they carefully explain the various types of assistance.

"Sometimes people have apprehension about applying for assistance for one reason or another," says **Bethanne Keating**, associate director of patient financial services registration. "Patients have never been on charity before. They are unaware of all the different types of assistance programs."

• Undocumented patients sometimes provide inaccurate Social Security numbers.

"They don't realize they are potentially eligible for assistance. They give us a Social Security number because they think they need one, and we find it's their child's or someone else's. That slows down the process," says Keating.

Patients are more forthcoming when staff members first explain that no information will be shared with the Immigration and Naturalization Service. Then they ask the patient, "Where were you born?" instead of asking about their legal status.

• Patients don't always follow up with requirements.

Because state and federal programs will deny patients coverage if they fail to submit required documentation, patient access employees "hold their hand through the process," says Keating. Staff members ask patients to bring required documents directly to them, so employees can be certain they're submitted, for example.

"We follow up with patients at their future clinic appointments. We contact employers for needed information, such as verification of income," adds Keating. *(See related stories on fraud prevention, below, and how to keep staff updated on changes in eligibility guidelines, p. 80.)* ■

Access took steps to combat fraud

If a patient insists he has no income, but he isn't in arrears for a $1,200 apartment and a $600 car payment, what does that tell you?

Patients sometimes report little or no income to patient access employees at Parkland Health & Hospital System in Dallas, but they refuse to provide any paycheck stubs or bank statements.

"There are always those few bad apples that want to deceive you and think that if they say they have nothing, they don't have to pay the bill," says **Bethanne Keating**, associate director of patient financial services registration. "We work hard to educate our community that this is not 'free care.'"

The patient access department made these changes, due to several recent incidents involving fraudulent claims made by patients:

• Staff members use a new interview process.

"We don't accuse patients, and we work hard to teach our staff not to interrogate. But we do ask probing questions in a non-threatening manner," says Keating.

Patient access employees tell patients, "You have a responsibility and a commitment to your healthcare as well. We are here to partner with you. To do that, we need truthful and accurate information. If you are honest and truthful with us, we are going to try and help you."

• Patients are reported to law enforcement if fraud

is suspected.

Robert Reed, vice president of patient access/patient financial services administration, says, "We have, in fact, prosecuted folks who have fraudulently gotten on our charity program, and are receiving restitution." An initial investigation is performed thorough the Dallas County District Attorney's office, he explains, and if it's determined fraud has occurred, the matter is escalated to the Dallas County police department.

• Employees stress to patients that they are going to verify their address and income.

Occasionally, patients falsely claim to live in Dallas County to obtain charity care from the hospital. "We are not just taking their word for it," says Keating. "Word of mouth has worked well. We have learned that our population is very tight-knit and communicate with each other extremely well."

The department now uses third-party sources to perform credit checks and determine patients' approximate household income, based on their spending habits.

• Patient access employees use software to verify information, and they screen patients for various programs.

"Previously, if the patient went to a different financial counselor, he or she might have gotten a different answer," says Keating. "We took some of the subjective variables out of that." ■

Keep staff current on `ever-changing' rules

Obtaining documents to verify a patient lives in the state sounds simple enough, but it is sometimes challenging for patient access staff at Cox Medical Center Branson (MO).

"Our area has many people who are transplants from various parts of the nation who have not been living here for a very long length of time," explains **Rebecka Sandy**, CHAA, CHAM, team lead for patient access. "They may qualify for Missouri State Health insurance pool or Missouri Medicaid. But without residency documentation, our hands are tied."

Many times, registrars are able to obtain utility bills or credit card statements to use as proof of residency. In some cases, staff members have had to help the patient obtain a copy of their birth certificate in order to obtain a state-issued identification card.

Financial counselors now interview all self-pay patients to determine their ability to pay and whether they're eligible for the state health insurance pool program and entitlement programs. However, programs and eligibility guidelines are "ever-changing," says Sandy.

Patient access employees recently were able to enroll many patients in the federal health insurance pool for pre-existing conditions, for example, but no more applicants are being accepted. "We actually heard about closing of the federal insurance pool on the national news!" says Sandy. "This prompted us to inquire about the status with the administrator of the insurance pool within our state."

Patient access employees learned that only patients who were eligible prior to March 1, 2013, are able to keep their coverage until the end of 2013. "We are now only able to enroll new patients in the state pool, which does not cover pre-existing conditions as the federal pool did," she says.

Patient access managers work hard to keep staff updated on these and other program changes. "We frequently deal with patients that are from other states. It sometimes requires research to know the guidelines of their specific state," Sandy adds.

Knowledge of the eligibility guidelines of various programs soon will become even more important for patient access, predicts Sandy.

"Access to affordable healthcare is ultimately the goal. But we need to be able to direct people to what would work best for them," she says. "Being able to help the patient with these decisions reduces anxiety and raises patient satisfaction." ■

Patient portal gives access these benefits

Productivity is increased

Making or rescheduling appointments, accepting outstanding balances, or discussing scheduling were once tasks that could be handled by patient access employees only during business hours, but this situation has changed at University of Pittsburgh (PA) Medical Center.

Patients now request appointments online, view scheduled appointments, and reschedule appointments with a real-time online chat with a scheduling agent. They also can view and pay physician and hospital bills.

"Patients have one place to go to interact with both clinical and business personnel," says **Jennie Bartko**, director of revenue cycle and patient access.

Advanced scheduling functionality is being rolled

out department-by-department, which allows return patients to schedule their own appointments online. "Practice selection and patient scheduling patterns are important when beginning to deploy this feature," Bartko says. Of the two pilot groups — a primary care practice and a neurology practice — patients at the primary care office used self-scheduling more often. "We found the neurology patients return at more regular intervals," says Bartko. "They tend to schedule the next appointment with the specialist upon check-out."

Use of the direct scheduling option continues to grow as more physicians implement the process. More than 15 new practices have implemented online scheduling in the past six months.

Physicians were concerned that patients would not be scheduled correctly if patients were able to place themselves on the schedule, which was not the case. "The other concern was emergent patients scheduling themselves for an appointment and not seeking immediate treatment," says Bartko. "Patients complete a short structured questionnaire to help guide them through their self-scheduling activity."

Transactions increasing

Patients can make a single payment that is applied to open balances across multiple account statements. "Online bill payment has shown an increasing trend in both number of transactions and associated dollars over the past year," reports Bartko.

If patients have questions regarding their bill, they can send a secure message or participate in an online chat with a customer service agent. Patients receive an email letting them know when new information and messages are available for them to view in the patient portal. "As part of the scheduling and registration process, patients are queried to provide or confirm their email address. This is housed as part of their demographic information," says Bartko.

EXECUTIVE SUMMARY

Patients can now schedule and reschedule some appointments online at University of Pittsburgh (PA) Medical Center. This change has increased productivity in patient access areas.

- Physicians needed assurance that patients would be scheduled correctly.
- Primary care patients use self-scheduling more than neurology patients.
- Members of the patient access staff were freed up due to decreased call volume.

Because patients are completing many of the tasks previously performed by patient access staff, there is reduced call volume for clinical and business reasons. This change frees up employees for other tasks such as educating arriving patients, reconcile patient liabilities, and providing assistance to patients who are unable to pay.

"Expediting flow at the front desk allows you to move the patient into the clinical care pathway more quickly," says Bartko. "Future portal functionality will include online pre-registration; self-pay estimation for co-pay, coinsurance, and deductible amounts; and a simplified online account creation process." ■

Overcome obstacles to have happy patients

Identify the biggest dissatisfiers

Too much time spent waiting and too many phone calls were the two things that patients complained about most often regarding registration at Porter Adventist Hospital in Denver.

Patient access leaders learned this from the hospital's SHARE cards, which are used by patients, visitors, or staff to share suggestions, compliments, or complaints. The completed cards are sent to the managers of each department.

"When we receive these cards, we take them very seriously. We reward staff that get compliments, and we address the complaints and suggestions as they come in," says **Jeryl Wikoff**, formerly the hospital's patient access manager and current patient access manager at Castle Rock (CO) Adventist Hospital. Here is how patient access leaders addressed these top two patient dissatisfiers:

• Managers reviewed staff schedules to make sure there was adequate staffed for peak volumes.

"We ended up shifting our scheduling. We had a registrar come in 30 minutes early, to help with the morning surgery volume we were seeing," Wikoff says.

• Patient access employees pre-register 98% of patients at least two weeks out.

Staff pre-register patients while scheduling their appointments over the phone. "We do as much as we can during the scheduling piece so we can avoid an additional phone call," she says.

• Patient access staff members review all of the prep instructions for radiology procedures, so radiology doesn't have to make a separate call to patients.

"We also work benefits and price estimates two weeks out for our scheduled patients, so we can try

EXECUTIVE SUMMARY
Patients at Porter Adventist Hospital in Denver reported registration wait times and multiple phone calls were their two biggest reasons for dissatisfaction. Patient access leaders addressed these by:
• shifting staff schedules to accommodate peak volumes for morning surgery patients;
• having patient access staff review radiology instructions with patients to avoid a separate call;
• asking for payment over the phone to speed up registration times.

combining the pre-registration call with the patient portion call," says Wikoff.

• Patient access employees send letters to surgical patients that explain their benefits and insurance coverage, and it gives them a number to call at their convenience should they have questions.

"We also ask for payment over the phone when discussing benefits with the patient. This speeds up the registration time," says Wikoff. "We try to do as much upfront for the patient as we can."

SOURCE

For more information on improving patient satisfaction, contact:
• **Jeryl Wikoff**, Manager, Patient Access, Castle Rock Adventist Hospital. Email: JerylWikoff@Centura.org. ■

Healthcare assisters verses navigators

Open enrollment for coverage under the new healthcare marketplaces is set to open in about three month, and opponents of the law are raising new concerns with the plans.

Recently, CQ reported that Republicans in the House of Representatives have questioned the authority of the administration to provide "in-person assisters" in the program. The assistants, separate than the navigators provided for in the law, are also meant to help participants in the exchanges apply for insurance, the National Association of Healthcare Access Management reported.

Gary Cohen, the director of the Center for Consumer Information and Insurance Oversight, acknowledged that an assister was "essentially the same" as a navigator. Navigators are persons that will help customers choose which insurance plan to pick, and they will help determine whether they are eligible for Medicaid or tax credits. Navigators are paid with federal funds, however, and states that are running their own exchanges are barred from federal money. Still, a mandate of all exchanges it to provide outreach, education, and enrollment assistance. This poses an issue for states whose exchanges have not yet become independently viable.

The House Oversight and Government Reform Committee held a joint hearing in May with the subcommittees on Energy Policy, Health Care and Entitlements and on Economic Growth, Job Creation and Regulatory Affairs. After, the chairmen sent a letter to HHS Secretary Kathleen Sebelius expressing concern over the role of the in-person assisters. They stated that they didn't see any statutory authority for the assister program and that there is no functional difference between the assisters and the navigators. ■

Navigators spark debate from Republicans

As specifics about the health insurance exchanges continue to come out, opponents continue to scrutinize and criticize regulations. Recent concerns, according to CQ, come from Republicans who are worried about the role that navigators will play in the marketplace, the National Association of Healthcare Access Management reports.

The navigators are needed because "many people who would buy insurance through the marketplace have never had insurance before and will need help in choosing the right plan" says **Gary Cohen**, director of the Center for Consumer Information and Insurance Oversight in the Department of Health and Human Services (HHS).

Congressman **Tim Murphy** (R-PA), a member of the House committee on Energy and Commerce, agrees that there needs to be a helper, but he disagrees with HHS's idea. HHS plans to fund the navigators with $54 million in grants that will be spread across the 33 states that have a federally run exchanges or a state-federal partnership. Murphy announced at a hearing that the role can be filled by insurance brokers, paid by private sector companies instead of the federal government.

HHS leaders disagree with Murphy and emphasize the need for the navigators to be independent. Otherwise, they fear, brokers will be more focused on selling their company's plan to the customer, even when it might not be the right plan for them. Regulations set down by HHS bar licensed brokers and insurance agents from acting as navigators, but it allows them to assist people in signing up for coverage. This approach

worries some Republicans who fear that those experienced in the insurance industry will not be able to help, which leaves the navigator roles to be filled by inexperience newcomers.

These navigators will finish their training in August before the public starts seeing eligible plans in September. The open enrollment period begins in October, and all marketplace plans will cover individuals beginning January 2014. ■

Outdated technology costs hospital money

A new study conducted by the Ponemon Institute and reported by USA Today's "CyberTruth" finds that hospitals are absorbing an estimated $8.3 billion annually due to outdated technology. The losses are due to lost productivity and increased patient discharge times caused by the old technology, the National Association of Healthcare Access Management (NAHAM) reports.

According to the study, clinicians waste an average of 46 minutes per day waiting for patient information. Specifically, 37 minutes of the average discharge time of 102 minutes is due to waiting for hospital staff members to respond with information necessary for the patient's release. Other lost time is due to inefficient pager systems, no Wi-Fi access, and bans on the use of personally owned devices.

NAHAM reported previously that the Obama administration authorized $19 billion in 2009 to promote the use of electronic medical records. The program reimburses doctors and medical facilities for expenses that can provide "meaningful use" in advancing medical technology at their facility.

Some facilities are adopting technologies such as secure text messaging systems that staff members can download to their personal phones. One program in particular encrypts text messages that it sends, and it stores the messages so that they can be audited. Other technologies include the implementation of a virtual desktop system so staff members only have to remember one password to log onto terminals anywhere in the hospital.

Unique challenges within the healthcare industry may prevent rapid implementation of new technology and cause the lag in technology. Security and privacy policies mandated by law, for example, must be taken into account for any upgrades. Competing electronic health record vendors and the lack of a national EHR infrastructure further complicate matters. To see the CyberTruth report, go to http://usat.ly/141UgXl. ■

HHS department revises insurance marketplace form

In March, the National Association of Healthcare Access Management (NAHAM) reported that the draft Health Insurance Marketplace application ran 15 pages for a family of three, with some versions going as many as 21 pages. Responding to feedback, the Department of Health and Human Services (HHS) has released a shortened form that runs just five pages for a single applicant and beginning at 12 for families, NAHAM reports.

According to an article in the *The Washington Post*, the new form "essentially scaled back [the] draft application that could cover all applicants to one that covers the most common, basic cases of those who apply for insurance assistance. Different forms will be available for the more complex cases." The form also includes a page of instructions and another page if the applicant wants to designate someone to help them. The revised form has won over groups who criticized the first version, such as Families USA, but there are some expectations that it will not be used much. A lot of the applicants probably will apply online, where information will be collected in a different manner. Others may use customer navigators who are tasked with helping applicants figure out which insurance option suits them the best, according to the *Post*. To access the *Post* article, go to http://wapo.st/100lQkn.

This action came in the wake of a poll by the Kaiser Family Foundation that found that 42% of Americans thought that the Affordable Care Act was no longer law. Included in the 42% are 12% that believe the law was repealed by Congress, 7% that believe it was struck down by the Supreme Court, and 23% that didn't know the current status of the law. For more information on the poll, go to http://bit.ly/Zr7rxD.

Open enrollment for all uninsured citizens is

COMING IN FUTURE MONTHS

- Offer patients immediate, accurate estimates
- Inform confused patients about their coverage
- Boost collections by making clinical staff allies
- Prevent Medicaid enrollees from losing coverage

set to begin in October, with coverage to begin in January of 2014. ■

Universal health records — Will they ever happen?

Electronic health records (EHRs) have gotten increased support from federal policy and private enterprise over the past few years, according to the National Association of Healthcare Access Management (NAHAM).

New models of health information technology have given doctors and patients alike a clearer vision of what healthcare could and should look like, according to recent article in *Forbes*. The article cites several ideals that have come out of the models, including complete medical records that will be sent to all of the patient's doctors and fostering communication between a patient's primary care physician and hospitals or specialists. EHRs also can serve as a consistent and lifetime health record that can assist in illness prevention as well as treatment.

Patient access professionals have been advocating for EHRs, and they have cited the enhanced patient identity integrity. NAHAM's Public Policy and Government Relations Committee also has been talking about this topic and is developing a public policy statement regarding the need for enhances patient identity integrity.

The *Forbes* article cites a survey reporting that 70% of doctors now use EHRs, past what most believe is the "tipping point." These systems might be able to save patients and doctors money in the long run, despite the cost upfront. The savings is somewhat mitigated, however, when the systems cannot communicate with one another. When this happens, patients still have to rely on paper forms to request records from one doctor to give to another. This process, besides being inefficient, puts the burden on the patient to figure out which records go to which doctors.

To combat this problem, Forbes suggests that all clinics, practices, hospitals, and testing sites provide patients a standard, printed statement at each visit, detailing how (and whether) its staff will transmit records to other physicians and specifying what procedures, if any, patients need to take on their own to facilitate transfers. While old fashioned, these steps still are needed until a universal health records system can replace it, the article says. To read the *Forbes* article, go to http://onforb.es/13LPKvL. ■

Patient Access Registration Ladder Requirements

Patient Access Registrar Ladder Requirements

Effective Date:_____ Last Reviewed: 8-10-2012

Last Revised:_____

Next Scheduled Review Date:_____

Authorization:_____ _____

PURPOSE – The purpose is to provide a fair and consistent procedure to evaluate and promote Patient Access staff that demonstrates increased technical expertise, decision making capabilities, accuracy proficiency, and team building qualities.

POLICY – It is the policy of Cottage Hospital to classify Patient Access staff according to levels of demonstrated expertise and proficiencies for the purpose of salary administration, job requirements, and expectations.

RESPONSIBILITY – It is the responsibility of the Director of Patient Access r to monitor the staff's proficiency and competencies for the staff advancement and promotions on a consistent basis.

LADDER DEFINITION– A Patient Access Registrar will be classified as a Registrar I, Registrar II, Registrar III, Registrar IV, or Resource Specialist based on experience and expertise of the job.

1. **Registrar I** – Is an entry level position with no previous experience working in a Patient Access customer service environment. The Registrar will demonstrate the ability to multi task, operates and directs switchboard calls efficiently/correctly, maintain an accurate rate of 95% or greater, demonstrates team concept of duties, demonstrate strong customer service skills; attend monthly staff meetings, and the ability to communicate effectively.
2. **Registrar II** – Is a position that requires a Registrar to accurately process a registration/ admission with correct payer and demographics, possess excellent customer service skills, attend monthly staff meetings, and are cross trained to cover 2 ancillary departments. A Patient Access Registrar II must still maintain 95% proficiency in all job related responsibilities, and

duties as assigned. Demonstrates team concept and the ability to communicate effectively and complete requirements of previous levels.

3. **Registrar III** – Is a position that requires a Registrar to show expertise in registration, admissions, managing patient accounts accurately, insurance eligibility work list reporting, collection experience, possess excellent customer service skills, attend monthly staff meetings, and are cross trained to cover 3 hospital departments. A Patient Access Registrar III must maintain 95% accuracy proficiency in all job related responsibilities, and duties as assigned. Demonstrates team concept and the ability to communicate effectively and completed requirements of previous levels.
4. **Registrar IV** - Is a position that requires a Registrar to show expertise in registration, admissions, managing patient accounts accurately, insurance eligibility work list reporting, collection experience, possess excellent customer service skills, attend monthly staff meetings, and are cross trained to cover 4 or more hospital departments. A Patient Access Registrar IV must maintain 96% accuracy proficiency in all job related responsibilities and duties as assigned. Demonstrates team concept and the ability to communicate effectively and completed requirements of previous levels.
5. **Patient Access Supervisor** – Is a position that will only be given to one staff member who has demonstrated expertise in Patient Access department processes. This position requires a Registrar to demonstrate a minimum of 97% accuracy proficiency for patient registration & admission expertise and all job related responsibilities, duties as assigned, possess excellent customer service skills, attend monthly staff meetings, accurately compiles timesheets, and are cross trained to cover all ancillary departments. This position also requires a minimum of 3 years registration experience, 6 months requirement of error reporting, Q/A reporting, has successfully acted as back up to the Director of Patient Access during the presence of or absence thereof, corrective maintenance on accounts, insurance verification work list reporting, represent the department on hospital committees, department head meetings, and all other duties as assigned by the Director of Patient Access.

PROCEDURE:

1. Advancement from Registrar I to Registrar II:

a. Demonstrates 95% proficiency in all aspects of the patient registration process.

b. "Meets the expectation" on the annual performance evaluation for all requirements.

c. Ability and willingness to plan for and perform additional duties, responsibilities, and functions as assigned.

d. Ability and willingness to be flexible in covering open registration shifts, including 2nd shifts, weekend shifts, and shifts within other departments in which the Registrar has been trained to cover. Demonstrates a positive attitude and willingness to participate as a team.

e. Active participation in quality assurance and performance improvement initiates in conjunction with the department Director.

f. Successfully complete all in house training courses.

g. Has maintained attendance and punctuality as defined in Cottage Hospital Policy.

h. Attends staff meetings, only having up to 2 excused/absences in a 12 month period.

Maintenance:

The Registrar must maintain a registration accuracy of 95% proficiency in all aspects of the patient registration process, and responsibilities as evidenced by an annual performance evaluation with a minimum rating of "meets the standard" on all requirements; the Registrar cannot have any "does not meet the standard". The employee level will be re-evaluated at the semi-annual review and if necessary, further education and corrective actions will be implemented to bring the employee requirements to meeting the standard.

2. Advancement from Registrar II to Registrar III.

a. Demonstrates proficiency requirements in all aspects of the patient registration process.

b. "Meets the expectation" on the annual /semi-annual performance evaluation for all requirements.

c. Demonstrates successful team leadership by providing direction, focus control and effectively assists with facilitating and implementing goal achievement.

d. Provides effective mentoring, training, and serves as the departmental expert resource for the assigned specialty within the department

e. Is responsible for assisting with the active and ongoing quality assurance and process improvement initiatives within the department in conjunction with the department Director.

f. Attends staff meetings, only having up to 2 excused/absences in a 12 month period.

g. Has developed and maintained effective working relationships as a liaison from the Patient Access Department to other departments within the hospital and with external third parties.

h. Consistent attendance and punctuality according to Cottage Hospital Policy.

i. Volunteers for 2 or more Cottage Hospital sanctioned events.

j. Serves as a Patient Access representative on Cottage Hospital committees as directed by department Director.

Maintenance:

The Registrar must maintain a registration accuracy of 95% proficiency in all aspects of the patient registration process, and responsibilities as evidenced by an annual performance evaluation with a minimum rating of "meets the standard" on all requirements; the Registrar cannot have any "does not meet the standard". The employee level will be re-evaluated at the semi-annual review and if necessary, further education and corrective actions will be implemented to bring the employee requirements to meeting the standard.

3. Advancement from Registrar III to Registrar IV

a. Demonstrates 96% quarterly proficiency requirements in all aspects of the patient registration process.

b. "Meets the expectation" on the annual /semi-annual performance evaluation for all requirements.

c. Demonstrates successful team leadership by providing direction, focus control and effectively facilitates goal setting and goal achievement.

d. Provides effective mentoring, training, and serves as the departmental expert resource for the assigned specialty within the department.

e. Is responsible for active and ongoing quality assurance and process improvement initiatives within the department in conjunction with the department Director.

f. Attends staff meetings, only having up to 2 excused/absences in a 12 month period..

g. Has developed and maintained effective working relationships as a liaison from the Patient Access Department to other departments within the hospital and with external third parties.

h. Consistent attendance and punctuality according to Cottage Hospital Policy.

i. Volunteers for 4 or more Cottage Hospital sanctioned events.

j. Serves as a Patient Access representative on Cottage Hospital committees as directed by department Director.

k. Become one of the designated Registrar Trainers for new hires.

Maintenance:

The Registrar must maintain a registration accuracy of 96% proficiency in all aspects of the patient registration process, and responsibilities as evidenced by an annual performance evaluation with a minimum rating of "meets the standard" on all requirements; the Registrar cannot have any "does not meet the standard". The employee level will be re-evaluated at the semi-annual review and if

necessary, further education and corrective actions will be implemented to bring the employee requirements to meeting the standard.

4. Advancement from Registrar IV to Patient Access Supervisor

a. Demonstrates 96% quarterly proficiency requirements in all aspects of the patient registration process.

b. "Meets the expectation" on the annual /semi-annual performance evaluation for all requirements.

c. Demonstrates successful team leadership by providing direction, focus control and effectively facilitates goal setting and goal achievement.

d. Provides effective mentoring, training, and serves as the departmental expert resource for the assigned specialty within the department.

e. Is responsible for active and ongoing quality assurance and process improvement initiatives within the department in conjunction with the department Director.

f. Attends staff meetings, only having up to 2 excused/absences in a 12 month period.

g. Has developed and maintained effective working relationships as a liaison from the Patient Access Department to other departments within the hospital and with external third parties.

h. Consistent attendance and punctuality according to Cottage Hospital Policy.

i. Volunteers for 4 or more Cottage Hospital sanctioned events.

j. Services as a Patient Access representative on Cottage Hospital committees as directed by department Director.

k. Become one of the designated Registrar Trainers for new hires.

l. Accurately review and correct payroll sheets on a weekly basis.

m. Run all daily accuracy reports to review and delegate for corrections.

n. Run Patient Access staff meetings in the absence of the Director of Patient Access.

o. Will find and/or delegate coverage responsibilities for unscheduled absences; the Patient Access Resource Specialist will be the last resort for coverage.

p. Will assume the role of second in charge of the department behind the Director; will also be the point of contact in the absence of the Director.

Maintenance:

The Registrar must maintain a registration accuracy of 97% proficiency in all aspects of the patient registration process, and responsibilities as evidenced by an annual performance evaluation with a minimum rating of "meets the standard" on all requirements; the Registrar cannot have any "does not meet the standard". The employee level will be re-evaluated at the semi-annual review and if necessary, further education and corrective actions will be implemented to bring the employee requirements to meeting the standard.

5. Prior to the Registrar's annual evaluation he/she must submit a request for consideration for Patient Access Registration Ladder advancement by following the steps listed below:

a. Complete a self-assessment that specifically addresses the qualifications for advancement outlined above.

b. Provide evidence of successful completion of management approved training and/or educational courses. This may include, but is not limited to college courses, home/self study programs, and computer training seminars/meeting, sponsored by professional organization such as NHHA, HFMA, NEAH, and NAHAM.

c. Schedule an interview with the Director of Patient Access.

The Director of Patient Access will evaluate the applicant's qualifications for advancement and make recommendation to the CFO within two weeks of the applicant's interview.

The applicant will be notified of the results of the advancement request within 30 days, with reasons for decision.

Unsuccessful Registrar applicants are eligible to reapply for advancement consideration at his/her next annual performance evaluation

Revised 5-5-2012

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