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Access is too often shortchanged with staffing: Justify your needs!

Data can prove need for additional FTEs

Recently, patient access leaders at Tufts Medical Center in Boston finally were able to hire a dedicated FTE focusing on denials.

"This person has become a key resource in denials management and identifying processes upfront to prevent the denials," says **Alyson Landry**, manager of ambulatory operations and training.

Without this approach, claims denials become "downtime" work, and staff members are not fully engaged in this process, says Landry.

Tufts' patient access leaders were able to justify this additional FTE by demonstrating the volume of denials related to lack of authorization and attaching a dollar amount to it. "In our organization, access has historically been overlooked as far as staffing. We have worked to improve this over the last three years, but we continue to have challenges," says **Nicole Marsoobian**, manager of patient access.

First, patient access leaders need to appropriately measure staffing to justify it, emphasizes **Tanya Powell**, patient access director at Ochsner's Northshore Region Facility and Clinics in Slidell, LA. "For registrars, there is so much 'prep' work done, that is not measurable, to get the patient in the door," Powell says.

Next month: Special issue on upfront collections

The January 2014 issue of *Hospital Access Management* will be a special issue on upfront collections. We'll report on cutting-edge practices, dramatic success stories, and the biggest challenges patient access is facing in moving collections to the front end. In addition, we'll cover how collection processes need to be revamped due to the implementation of the Affordable Care Act.

AHC Media

Initially, Tufts Medical Center's patient access leaders lacked the ability to track volume of work, productivity, and integrated statistics from various systems and tools. "The issues that arose as a result include a backload of registrations, billing denials, and overworked, disengaged staff," says Marsoobian.

Justifying staffing is increasingly important for patient access in light of continual changes in insurance plans and pre-visit requirements, she says. "We have had many discussions around shifting some of the resources in the billing area to focus on previsit work, in order to prevent the volume of work and denials after the fact," says Marsoobian. "The next step is to figure out how to do this."

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EXECUTIVE SUMMARY

It is often difficult to justify additional FTEs in patient access areas, because leaders lack the ability to measure staffing needs. Patient access leaders at Tufts Medical Center in Boston added an additional FTE by showing the cost and volume of "no authorization" denials.

- Leaders need to track productivity and work volume.
- Data on volumes of calls, new patients, uninsured, and underinsured patients is needed.
- Some managers spend time performing patient access functions to fully understand all that staff do.

Data is the key

Landry says patient access leaders need the following data: Call volumes, new patient volumes, referral and authorization volumes, volume of uninsured and underinsured patients, and additional work stemming from updates received via fax, forms from clinics, and updates from billing.

According to Landry, closely tracking these numbers is the key to justifying additional FTEs. *(See related story, p. 135, on technology to help patient access prepare for a surge in volume.)*

"We have certainly put in place various tools to assist in understanding productivity," says Landry. "However, what we struggle with most is the manual processes that are still in place. These do not allow us to track the additional work efforts of our staff." These manual processes include emails, backline calls, and faxed updates.

Landry and other patient access managers do "intense manual audits," which entail spending full eight-hour days with the staff. "We assess everything that is coming to them," she says. "We actually spend time performing the access function to fully understand the issues."

SOURCES

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Use software to prepare for surge

If the expected surge in patient volume under the Affordable Care Act materializes, does that mean patient access staffing will need to increase commensurately?

"Healthcare reform will be bringing more patients to the hospital. Initially, this will affect the patient access department," says **Ankeny Minoux**, president of the nonprofit Foundation for Health Coverage Education (FHCE). Minoux is chief operating office of PointCare, a software product that resulted from a study done by San Diego, CA-based Sharp Healthcare and the FHCE that focused on hospitals taking on a greater role in signing up uninsured patients at the point of care to help their bottom lines.

"'Staffing up' can be minimized for hospitals, by having clear and concise procedures in place and by using navigation software available in the marketplace today," says Minoux.

PointCare's proprietary database, updated real-time, can access all public and private health insurance options in all states, including health exchanges plans, coverage subsidies, tax credits, and it is customizable to include the healthcare facility's charity care programs. "Currently, PointCare is the only screening and enrollment technology that instantly screens for all public and private programs nationwide," says Minoux. "Most competitors only screen for between three and 10 programs, but are doing so using a paper-based model."

Continuing to use manual processes for identifying health insurance options for the uninsured just isn't a viable option for today's patient access departments, she underscores.

"Those who will emerge successfully from reform's changes must focus their efforts on conducting a consistent and accurate screening, of every program, for every patient, every time," she says.

RESOURCE

• **PointCare** is a screening and screening and enrollment technology that screens for all public and private programs. The rates for a facility range from $2,500 to $7,500 monthly, and systems with multiple facilities are priced separately. For more information, contact PointCare, San Mateo, CA. Phone: (650) 762-1928. Email: pcpainfo@pointcare.com. Web: www.pointcare.com. ■

Abandoned calls cut from 13% to under 4%

Switch to centralized scheduling

By switching to a centralized approach to scheduling, patient access leaders at University of Kentucky (UK) Healthcare in Lexington reduced the phone call abandonment rate from 13% to under 4%.

"This reduction of the abandonment rate means we are able to serve approximately 270 more callers each day than we were four years ago," reports **Lori S. Bruelheide**, assistant director of enterprise patient access services.

Higher abandonment rates lead to frustrated patients and repeated phone calls. "Reducing this rate has many positive effects," she says. These steps were taken to achieve the lower abandonment rate:

• Managers evaluated the automated greetings on the phone lines that provide patients with choices.

"We wanted to make these as concise and consistent among clinics as possible," says Bruelheide.

In general, the "call trees" follow this standard model: Press 1 to schedule. Press 2 for a prescription refill. Press 3 to speak to a nurse. There are occasional additional options for other languages or a particular physician's nurse.

"We still have some variances among specialties. But we strive to have no more than three options for each call tree," says Bruelheide. "This minimizes patient frustration and confusion."

• Managers worked with staff to reduce the average hold time to about 30 seconds before a live agent greets the caller.

EXECUTIVE SUMMARY

Patient access leaders at University of Kentucky Healthcare in Lexington reduced the phone call abandonment rate from 13% to under 4% due to switching to centralized scheduling.

• Automated greetings were made concise and consistent.

• Average hold times were reduced to about 30 seconds.

• Job descriptions were rewritten to focus on scheduling.

"We have found that the abandonment rate is directly proportional to the hold time of the caller," says Bruelheide.

Easier scheduling

Several years ago, UK Healthcare's patient access leaders became aware that patients were very dissatisfied with the scheduling process. In particular, the problem centered around the patient's ease of obtaining an appointment — or lack thereof.

At that time, the department had multiple phone systems and a decentralized scheduling model. "This often resulted in patients being unable to determine how to reach the desired clinical area by telephone," says Bruelheide.

Patients found themselves being transferred within and between departments because they had called an incorrect phone number for scheduling. "Our decentralized scheduling model also led to understaffing of the scheduler positions in many areas," says Bruelheide. "Staff members had too many clinic responsibilities to devote sufficient time to scheduling."

In 2009, the organization developed a Patient Access Center to ease the process of scheduling appointments. The Patient Access Center schedules for 85% of ambulatory services and takes approximately 60,000 phone calls each month. "Our patient satisfaction with ease of obtaining an appointment, as reported on patient surveys, has risen dramatically during this time period," says Bruelheide.

Managers changed the job title of the individuals transitioning from the clinic scheduling role to the Patient Access Center scheduling role, from "patient relations assistant" to "customer access assistant." "This allowed us to rewrite the job description to focus on the scheduling aspect of the position," says Bruelheide. "We eliminated other 'front desk' tasks, like medical records preparation."

Managers used the new job title to focus the efforts of the staff members solely on the incoming phone calls. "That, in turn, contributed to our improved hold times and abandonment rates," says Bruelheide. "These individuals no longer have to leave their phones to perform other tasks."

Fewer FTEs needed

Before switching to a centralized approach, scheduling at Cincinnati Children's Hospital Medical Center was "completed in silos," says **Chris Korneffel**, director of scheduling center operations. Each department could schedule only its own specific services.

"Patients sometimes had to call multiple phone numbers or departments to schedule all of their treatments or needed services," says Korneffel.

There are now seven scheduling teams, with each comprised of three to seven departments, depending on the complexity of the scheduling. "This model allows scheduling with fewer FTEs than utilized prior to centralization, and the ability to answer more calls," says Korneffel.

Previously, a scheduler who worked in the orthopedic department only scheduled orthopedic services. After centralization, the scheduler now performs front-end scheduling processes for patients seeking services in allergy, pulmonary, international adoption, infectious disease and sports medicine, in addition to orthopedics.

The centralized call center now averages between 2,200 and 2,400 inbound calls per day, and 1,000 to 1,300 outbound calls per day. "Our average speed of answer is 37 seconds, our average abandon rate is 3%, and our average handle-time is 3 minutes and 45 seconds," says Korneffel. *(See related stories on standardization of registration process, below, obtaining physician buy-in, p. 137, and improving patients' ability to obtain an appointment, p. 137.)*

SOURCES

For more information on centralizing scheduling in patient access areas, contact:

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• **Chris Korneffel**, Director, Scheduling Center Operations, Cincinnati (OH) Children's Hospital Medical Center. Phone: (513) 636-5474. Email: Chris.Korneffel@cchmc.org. ■

Put a stop to inconsistency!

Standardize registration processes

If a patient continually encounters different processes throughout your organization for scheduling, registration and check-in, he or she is very likely to become frustrated.

"It can give the appearance of lack of cohesion and communication," says **Lori S. Bruelheide**, assistant director of enterprise patient access services at University of Kentucky (UK) Healthcare in Lexington.

While some specialty clinics permit patient self-referrals, others require that the patient's primary care physician refer the patient and coordinate the initial

appointment. "Similarly, there may be nuances related to pre-visit testing for a specific clinic that may appear to the patient to be a delay in care," says Bruelheide.

Variations such as these can cause the patient to have a very different experience scheduling with clinic A than with clinic B, which makes the healthcare organization difficult for the patient to navigate. "To overcome this perception of disparity, we have worked to identify areas where standardization can be achieved," says Bruelheide. These changes were made:

• Staff use standard phone greetings and phrases for all clinics to improve the appearance of consistency between clinics.

All patients are now greeted with, "Thank you for calling UKHealthCare, Department of _____. How may I help you?"

"We also request patient identification in a standard way, which helps repeat callers know what to expect when calling," says Bruelheide.

Previously some departments always requested the patient's Social Security number as the primary identifier, but all staff now ask callers for their name and date of birth for identification.

• The appointment reminder letter was standardized, so that each clinic's letter contains the same information in the same order.

"We have moved from a paragraph format letter to one that looks more like an invitation," says Bruelheide. This format provides a separate line for each piece of information: clinic name, clinic address, physician name, and date/time of appointment.

• All clinic front desk personnel wear the same uniform of a blue shirt with a UKHealthCare logo and khaki, blue, or black pants.

"This provides a more interrelated appearance within our clinic areas," says Bruelheide. "They may also choose to wear an approved UKHealthCare logo jacket, sweater, or neck tie, but those items are optional." ■

Get physician buy-in for change

Explain what centralized scheduling will do for them

When switching to centralized scheduling, it quickly became apparent to patient access leaders that buy-in "from the top down" was needed to pave the way.

"Most physicians were not familiar with a centralized scheduling concept and showed some apprehension," says **Chris Korneffel**, director of scheduling center operations at Cincinnati (OH) Children's Hospital Medical Center.

To quickly gain physician buy-in, patient access leaders personally met with department leaders. They explain that these benefits would be possible with centralized scheduling:

• that the entire scheduling process would be taken out of their hands;

• that there would be less wait time for their patients;

• that there would be fewer mistakes, because patients are more likely to be scheduled correctly due to detailed scheduling questionnaires within the scheduling system;

• that quality would be improved, due to formalized call monitoring and auditing.

In addition, leaders in the scheduling center visited each department separately to learn special circumstances or cases encountered, nuances, processes, and policies. "This allowed the team to build relationships with each division's leadership, as well as the first line staff, resulting in a trusting partnership," Korneffel says.

By spending time with the division staff and with each provider, a concise template for scheduling rules for each department was created and implemented. "During this process, we attempted to standardize rules and processes as much as possible," says Korneffel. "This was important for standardization and finding efficient workflows." ■

You can achieve timelier appointments

Like most large healthcare organizations University of Kentucky (UK) Healthcare in Lexington struggles with access to timely appointments, especially for some of its advanced specialties.

"In many of our specialty areas, patient demand for appointments outpaces the supply of available physician time considerably," says **Lori S. Bruelheide**, assistant director of enterprise patient access services.

In 2011, patient access leaders began closely monitoring the third next available appointment at its main scheduling locations. "This analysis has led to significant improvement of appointment availability in many areas," says Bruelheide. These steps were taken by patient access managers:

• They began by looking at all areas with anecdotally poor appointment access.

• They worked with each clinic to determine if the access problem was a demand/supply issue, or if there

were other physician scheduling preferences constricting the schedules.

"For example, are there simply more dermatology requests than we have appointments? Or are we attempting to throttle the demand by booking certain diagnoses on certain days?" asks Bruelheide. "We found a bit of both in our research."

• They established a goal of 10 days and started publishing their data.

"Once we did that, we found a large number of our clinics were very interested in being a top performer for this metric," she says. "They found creative ways to increase capacity for new patients."

Eighty percent of the evaluated clinical areas are now meeting the goal of scheduling a new patient appointment within 10 business days or less.

Strategies to increase capacity included physician recruitment, fully utilized clinic sessions, improved scheduling templates, and a focus on make-up clinic sessions, when sessions need to be cancelled or bumped. "We have added quite a few physicians in the last few years, allowing us to add appointment slots," adds Bruelheide.

Managers also worked with established physicians and mid-level extenders to make sure that the most efficient appointment durations were used for each clinic. For example, if a new patient appointment can be done in 45 minutes instead of 60 minutes, that change adds 1.25 slots to each four-hour clinic session.

"We also had great support from our executive leadership and our medical directors to ensure that clinic sessions are fully utilized — specifically, that a session begins at 8 a.m. and runs until 12 p.m., instead of 8:30 a.m. until 11:30 a.m.," says Bruelheide.

Wait lists were added to keep up with new patient demand in primary care departments. "This allows us to fill cancelled slots quickly," says Bruelheide. "This preserves the flow of the clinic and avoids a no-show or a gap in the physician's productive clinic time." ■

It's time to revamp your career ladder!

New requirements keep pace with changes

At University of Kentucky HealthCare in Lexington, a patient access career ladder had been in place for more than a decade.

"With the organization's changing priorities and external pressures of the marketplace, we felt the need to revamp our program," says **Courtney M. Higdon**, director of enterprise patient access services.

Higdon says the changes will offer a more consistent experience for patients. "We hope this prepares our staff for future roles in the organization where they may begin to have supervisory opportunities and take on broader roles," she says.

Higdon hopes to see internal transfer rates decrease. "We do have a lot of movement internally across the organization in [patient access] positions," she says. "Some of that is due to the historical variances that existed in how the program was implemented and executed throughout the organization."

A two-tiered program is now used, instead of the previous three-tiered program. One reason was that the evolution of the patient access role made it more difficult to differentiate the positions into three levels. *(See related story, p. 139, on other changes that were made to the career ladder.)*

The previous program used three titles: patient relations assistant I, patient relations assistant II, and patient relations assistant III, while the new program has only two: patient relations assistant and patient relations associate.

"Also, market studies showed that our entry-level position was below market in terms of compensation," says Higdon. "Eliminating that level made sense."

"People skills" made a priority

Patient access leaders at the University of Michigan Health System in Ann Arbor first created a career ladder in 2004, called The Registration Progression Model.

"We sought to equip employees with the technical tools needed to be successful in their current role and to prepare them for higher levels of skill and responsibility," says **Douglas Weaver**, director of patient financial counseling, registration, and

EXECUTIVE SUMMARY

Patient access leaders are finding the need to overhaul their existing career ladders to keep up with the fast-changing role of patient access. Managers are making these changes:

- Career ladders are made more consistent in all patient access areas.
- Criteria now include the number of claims denials.
- "People skills" are made a priority.

patient business services.

In 2007, the career ladder was overhauled and given a new name: The Registration Career Path. "We realized that while we had succeeded in equipping registrars with better tools and understanding of their work, we hadn't addressed some of the biggest obstacles to successful performance," Weaver says.

Eighty percent of the Registration Progression Model's criteria was aimed at technical job competencies. "Employees who received 'approaching' or 'not met' on performance evaluations were deficient in personal and social competencies," Weaver says.

The new career ladder balances technical and "emotional" competencies. "The focus on emotional competencies is to avoid, as much as possible, the employee who has star ability and fails due to less-than-stellar people skills," says Weaver.

As a result of the change, employee engagement and performance evaluation scores increased, the percentage of visits registered and payers verified increased, and registration-related claims denials decreased.

In 2013, the Registration Career Path was expanded to all of patient business services. It eventually will be rolled out to all revenue cycle staff. "The goal is to move people thoughtfully and methodically through logical career steps," says **Ellen Copeland-Brown**, manager of revenue cycle, learning, and performance improvement. Copeland-Brown expects the expansion of the career ladder to result in improved retention, as well as a more responsive workforce that can meet the challenges of a quickly changing healthcare finance landscape.

"We have learned that unless we remain diligent and committed to this program at all levels, it will already be outdated before we print the paper it is written upon," says Copeland-Brown.

SOURCES

For more information on updating patient access career ladders, contact:

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Access career ladder is new and improved

These changes were made to the patient access career ladder at University of Kentucky HealthCare in Lexington:

• The criterion for registration auditing was changed from measure of error rates in completing fields of a registration to denial rates by registrar.

"We moved to this approach to better align the work our registrars are doing with the organizational goals of reducing registration denials," says **Courtney M. Higdon**, director of enterprise patient access services.

Previously, managers evaluated particular fields for certain completion rates and values. That evaluation didn't necessarily guarantee the claim wouldn't get denied, however. "Now we are auditing our registrars based on their registration denials," says Higdon. "We are linking this performance to part of their overall annual performance evaluations."

• New requirements for performance evaluations and corrective action were added as criteria for promotion.

"We have taken deliberate steps through during this process to redefine this program to develop standard guidelines [that] managers across the organization can use to evaluate employees in these positions," says Higdon.

These guidelines are also quantitative metrics of performance. "They help address the challenges with subjective evaluations leading to organization variances in performance of staff in these positions," says Higdon.

Some of the performance metrics include standards of performance around delivery of service. "This is measured through an observation tool. We evaluate specific things we expect to see in any interaction with a patient or family member," says Higdon.

Additionally, there are metrics for registration and scheduling accuracy, completion of the Medicare Secondary Payer Questionnaire, and creation of duplicate medical records.

Staff members now have to complete additional training to qualify for promotion. "They must meet our standards for registration denials, demonstrate an 'above average' result on their performance evaluation, and not have been on corrective action for 12 months prior to being promoted," says Higdon.

• The training requirements of the positions were redesigned.

"We brought them in line with current organiza-

tional goals, focusing more specifically on customer service as the most important role of the position," Higdon explains.

Patient access leaders worked with the hospital's Office of Service Excellence to have a classroom training developed on service delivery, specific to the role of patient access. "Previous training was not-role specific. It was not a requirement of the position," says Higdon.

• Additional training is required for higher level team members, on leadership, mentoring, and process improvement.

"We expect our Level Two staff members to take on the responsibility of mentoring their colleagues," says Higdon.

The employees do not have supervisory positions, but they are recognized leaders within their teams. "They initiate discussions around improving workflows and processes unique to their areas," says Higdon. ■

Put physician orders at your fingertips

An incomplete order at the time of registration is a significant cause of frustration for patients, registrars, and physicians.

"It causes wait or hold times for the clinical staff as well as for our patients," says **Sharon E. Bright**, patient access manager at The University of Tennessee Medical Center (UTMC) in Knoxville.

UTMC's patient access leaders set goals to reduce the rework involving physician orders and to have all orders available prior to the patient's appointment. The department implemented a web-based application (Trace, developed by the Knoxville, TN-based White Stone Group) so that fax and electronic orders can be received in a single location.

When orders are missing a diagnosis or ICD-9 code or are non-compliant, staff members immediately fax the physician's office to alert them. "Prior to using this system, we had several departments involved in receiving and processing our physician orders," says Bright.

No more lost orders

Previously, when patients cancelled and rescheduled their appointments, the original orders often would be lost.

"Through this system, we now retain the original order," says Bright. "This is a really big plus for satisfaction with the physician's offices, because they don't have to refax the patient's orders."

Staff can search for orders by the patient's medical record number, patient name, date of birth, or account number, and locate them quickly and easily.

"Not only have we eliminated the faxing 'black hole,' but we have complete, ready-to-go orders for all of our patients—as well as satisfied physicians and clinical departments," says Bright.

24 hours notice

Harold Mueller, director of patient access and development at Barnes-Jewish Hospital in St. Louis, MO, says most problems with incomplete orders are prevented by preregistering patients 24 hours in advance.

At that time, staff members verify the patient's insurance, obtain an authorization if one is required, and verify that the order is complete. "If all that is done properly, things are pretty seamless," Mueller says. "Everything hinges on the work we do on the front end."

The last thing patient access staff want to do is tell a patient who has driven a long distance, "Your service is not covered by your insurance plan," or "There is a problem with the physician's order," he says.

If an order is incorrect, staff members have a day to resolve it with the physician's office, and sometimes enlist patients as allies in this process. Most often, says Mueller, the problem is that the physician's office has given incorrect insurance information for the patient. "We aren't a Kaiser-type model, with a closed panel of physicians," he says. "The physicians who schedule services here number in the thousands, so it does get more complicated."

EXECUTIVE SUMMARY

The patient access areas at The University of Tennessee Medical Center in Knoxville reached a goal to have all physician orders complete and available at the time the patient presents for services. These changes were made:

- A web-based application was implemented, so fax and electronic orders are received in a single location.
- Staff members alert the physician's office immediately if orders are incomplete.
- Staff members search for orders by the patient's medical record number, patient name, date of birth, or account number

Physicians' offices frequently give insurance information that is outdated, incomplete, or incorrect, such as a patient having different plan under a certain carrier. In some cases, patients had Blue Cross/Blue Shield coverage, but for a different state. "Any of that leads to some serious issues on our end. People think registration is easy, but it's not," says Mueller.

To avoid problems, patient access managers spend a lot of time educating staff on all the various permutations of plans. "We have a small training staff that works with our over 125 registration team members," says Mueller. "This includes employees on our campus and at our satellite outpatient facilities."

Each employee goes through about 25 hours in annual training specific to the payer marketplace.

"Because of all the different products within a certain plan, it gets very complicated," he says. "It's not instructions for one card they need to know; it's instructions for 300 cards."

SOURCE

For more information on ensuring complete physician orders, contact:
• **Harold Mueller**, Director, Patient Access and Development, Barnes-Jewish Hospital, St. Louis, MO. Phone: (314) 362-2326. Email: hpm9411@bjc.org. ■

Patient access is first to implement AIDET

Registration areas have 'culture of customer service'

In 2012, patient access areas at Baptist Health Richmond (KY) were first to implement Acknowledge, Introduce, Duration, Explanation, and Thank You (AIDET) as part of the organization's work with the StuderGroup.

"This specific tool has been critical for ensuring the patient experience begins with outstanding customer service, as soon as the pre-access or registration process begins," says **Jason Mouser**, director of patient access.

The hospital chose patient access areas as first to implement AIDET, because it is the only department that every patient has to encounter, says Mouser. "It was imperative that we begin with the first access point that patients experience when seeking services," he explains.

Every patient access employee has now been trained on adopting AIDET into their interactions with patients. All of the patient's questions and concerns are addressed. "This has been instrumental in helping reduce patient anxiety and opening the lines of communication," says Mouser.

The tool ensures that staff members communicate empathy, concern, and appreciation to patients, by making eye contact, smiling, greeting, and thanking them. "This has all led to an internal culture of quality customer service," says Mouser.

Set up for success

If patients are pleased with their registration experience, this perception sets up other departments and ancillary services for success, says Mouser.

"'Managing up' other employees and departments during patient registration conveys that we are dedicated and committed to outstanding customer service," he says.

Patients often tell patient access employees that they feel more informed before going to their intended area of service. "It is hardwired that patient access staff communicate to patients how long a specific test might take or even an estimated wait time in specific departments," says Mouser.

AIDET emphasizes the importance of telling patients the duration and explanation of procedures and wait times."We found this to be an area in need of improvement," says Mouser. "We capitalized on the opportunity to explain this in detail to patients."

To improve customer service in patient access areas at Lucile Packard Children's Hospital at Stanford (CA), employees are given ongoing training in Personalize, Communicate, Ask, Respond, Exit, and Sustain (PCARES). PCARES is a customized training developed by the hospital's Office of Patient Experience.

"The training provides the basic building blocks of providing good customer service over the telephone, specifically focusing on personalizing the phone call and ending with a 'final assist,'" says **Marta Miller**,

EXECUTIVE SUMMARY

Baptist Health Richmond chose patient access areas to be the first to implement Acknowledge, Introduce, Duration, Explanation, and Thank You (AIDET), a new customer service initiative, because it is the only department every patient encounters. Staff members do the following:
• Communicate empathy, concern, and appreciation to patients.
• Make eye contact, smile, greet, and thank patients.
• Give patients estimated wait times.

director of the Patient Access Service Center. "We QA and score the phone calls to make sure staff are executing these basic principles," says Miller. *(See related story, below, on holding staff accountable for customer service.)*

SOURCE

For more information on improving customer service in patient access areas, contact:
• **Jason Mouser**, Director, Patient Access, Baptist Health Richmond (KY). Phone: (859) 625-3695. Email: Jason.Mouser@bhsi.com. ■

Hold staff accountable for customer service

Customer service is included in the patient access job description at Baptist Health Richmond (KY), reports **Jason Mouser**, director of patient access.

"We have established service standards and behavior guidelines to help achieve a culture of exceptional service and quality," he says.

All staff members are held accountable to these standards: Accountability, Attitude, Communication, Compassion, Respect, and Integrity. During annual evaluations, if staff are unable to meet these standards, they are counseled by the management team.

The organization's Press Ganey patient satisfaction surveys include specific questions to evaluate whether registration staff members are providing excellent service. The emergency department survey includes questions about the helpfulness of the first person encountered by the patient, the courtesy shown to family and friends, and the adequacy of information given to the patient, family, and friends. The same-day surgery survey asks patients about the helpfulness of the registration person and the helpfulness of any phone personnel.

"Our Press Ganey scores have been consistently above the departmental mean benchmarks of 85.0," reports Mouser. ■

Take action to keep access staff happy

Simple changes are significant

Having "potluck" lunches on a regular basis has had a surprisingly big impact on the morale of many patient access employees at Cottage Hospital in Woodsville, NH.

"Just getting the team together has improved department morale," reports **Jennifer White**, director of patient access.

When an emergency department registrar at Mercy Hospital — Springfield (MO) told **Mike Spence**, MBA, financial analyst for patient access, that the night shift would no longer work for his family's needs, Spence found him a position in the outpatient department that gave him morning hours. "It allowed him to continue his career with Mercy," says Spence.

Too frequently, employees view patient access as a foot in the door to healthcare and choose to move on to clinical roles such as nursing or radiology, he says. "One reason is that as family schedules change, the needs of the employee change as well," says Spence. Caring for school-age children might make it impossible for an employee to continue working a night shift in the emergency department, for example.

"Of course, our facility is not immune to all of the typical reasons for attrition: better pay, better hours, or lower stress levels," he says. Here are ways to address each of these:

• Staff members want different hours.

In some cases, Spence has found a way to accommodate an employee's urgent need for a different schedule even if the right shift isn't available at the time. "We do occasionally allow a coworker to move into an open PRN position, until the right shift does become available for them," he says.

• Staff members want better pay.

"We have recently done a market rate adjustment and continue to monitor this in case further adjustments are warranted," says Spence.

The department also offers differentials for hard-to-fill shifts and registration areas such as the emergency department.

• Staff members want less stress.

Spence continually monitors workloads to be

EXECUTIVE SUMMARY

Employees might choose to stay in patient access instead of moving on to other roles if important issues such as scheduling changes are addressed by managers.
• Hold "potluck" lunches to get the team together.
• Allow a coworker to move into an open PRN position until the right shift becomes available.
• Monitor workloads so no position is overloaded or underloaded.

sure that any position isn't "overloaded or underloaded."

"Both can be detrimental," says Spence. "A bored employee is just as likely to leave to find something more challenging as an overloaded employee."

SOURCES

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In some states, most signing on to Medicaid

Enrollment starts for early marketplace

In several states, most of the people enrolling through new online insurance marketplaces are signing on to Medicaid, the state-federal health insurance program for the poor.

The reason? Many of the uninsured are poor, and applicants don't have to pay anything to sign up for Medicaid. Shoppers applying for private health coverage through the marketplace have to pay their first monthly premium before they are fully enrolled. Their first payment must be made by Dec. 15 for coverage to take effect Jan. 1. Most are expected to be eligible for some tax credits, up front, to help pay the monthly premiums.

"We believe the reason we are seeing the higher Medicaid numbers is many people [buying private health plans] will wait until the last minute to pay for their health coverage like many of us do with our cell phone or cable bill," said **Bethany Frey**, spokeswoman for the Washington state marketplace (http://www.wahbexchange.org).

About 30,000 of the more than 35,000 people enrolled in the Washington exchange have signed up for Medicaid. Under the health law, in states that opt into the expansion, Medicaid eligibility is being expanded to cover everyone with annual incomes under 138% of the federal poverty level, or $15,800 in 2013.

About 20,000 of the people who qualified for Medicaid in Washington gained coverage through the expansion, while the rest were eligible under existing coverage rules. Many of those who were eligible but not enrolled have been signing up as a result of the publicity around the new marketplaces, officials say.

Frey said about 56,000 additional people have completed applications to enroll in private plans in Washington but have not yet made a payment so they were not included in the state's tally.

About two-thirds of people enrolling through Kentucky's marketplace (https://kyenroll.ky.gov) also qualify for Medicaid, said spokeswoman **Glenda Bond**. "We expected Medicaid enrollment to be more robust at the beginning because people can enroll without making a payment," Bond said.

Not every state is seeing the trend, though. Of the more than 11,600 enrolled in Minnesota's marketplace, (http://www.mnsure.org), only about 2,500 qualified for Medicaid. That low number could be due to fact that the state already has had broad Medicaid eligibility levels.

Several states relying on the problematic federal exchange, including West Virginia and South Carolina, also have seen a surge in people applying for Medicaid because they have separate websites for Medicaid enrollment, which unlike the federal exchange site, are working. Other states, such as California, have not yet released data about what programs people have enrolled in. *(Editor's note: This story was reprinted from Kaiser Health News at http://capsules.kaiserhealthnews.org.)* ■

States to see surge in spending, enrollment

True even when not expanding Medicaid

Medicaid enrollment is expected to surge by nearly 12% next year in states expanding the program under the health law, but even states that will not expand eligibility project a 5% jump in the number of people enrolled in the state-federal health insurance program for the poor, according

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to a new report issued in October. (*To access the report, go to http://bit.ly/1b3ryst.)*

Total federal and state spending on Medicaid in 2014 is expected to increase 13% in states that expand eligibility, and nearly 7% in those not expanding, said the survey of state Medicaid officials by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. (KHN is an editorially independent program of the foundation.)

State spending growth was slightly lower for the 25 states that are moving forward with the Medicaid expansion (4.4%) compared to the remaining states (6.1%). The lower growth rates for the states that are expanding might be in part because many project they will save money as new federal dollars replace state spending on the poor, the report said.

Twenty-four states and the District of Columbia are expanding Medicaid to cover everyone under 138% of the federal poverty level, or $15,856 for an individual in 2013. *(Editor's note: For a list of the status of the states, as of Oct. 22, 2013, go to http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.)* The expansion was made optional by the Supreme Court last year. Although the federal government is paying full cost of the expansion through 2016 and no less than 90% thereafter, many Republican-controlled states said they could not afford the expansion.

States who opted against the expansion will still see enrollment and spending increase under existing eligibility guidelines because of intensive outreach efforts related to the health law and because the makes it easier to sign up for coverage through the new online health insurance exchanges, the report said.

Medicaid enrollment growth slowed in 2013 to 2.5% on average across the states — the lowest increase in six years since the since the start of the economic downturn. Overall, enrollment growth across the country should average 8.8% next year, the report said.

Increases in state spending reflect costs related to increased participation among individuals eligible for Medicaid reimbursed at a state's regular Medicaid match rate. These increases will occur in all states, even those not moving forward with the expansion. Only three states (Louisiana, Maine, and Wisconsin) projected that Medicaid enrollment would decrease in FY 2014. (*Editor's note: This story is reprinted from Kaiser Health News at http://capsules.kaiserhealthnews.org.)* ■

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Underinsured patients

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