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IN THIS ISSUE

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Access department's own on-site system analyst 'is the only way to go'

Benefit of immediate, specific problem solving is 'priceless'

Can you imagine the advantage of having a full-time systems analyst in the patient access department, working with access staff on a daily basis to solve information systems (IS) problems — days, maybe weeks before a service request would have been answered by your organization's IS department?

That situation is reality at the University of Pennsylvania Medical Center (PMC)-Presbyterian, where **Anthony Bruno**, MPH, MEd, director of patient access and business operations, has been creating an access department from the ground up since he joined the organization in July 2001. **(For some of Bruno's tips to access success, see the top-10 list on p. 135.)**

When Bruno learned that **Marilyn Williams** — a 30-year Presbyterian employee who most recently had been working with First Consulting Group (FCG), a national consulting firm to which the hospital had outsourced its IS operation — was about to accept a position with another health care system, he took immediate action.

"Marilyn had been working for me on numerous projects [while with] FCG, and I got to know her as someone with expertise in [Malvern, PA-based] SMS [computer systems] and with systems in general," he says. "Based on my observations and dealings with her, I felt it would be a tremendous hit for PMC to allow someone with her knowledge and background to leave."

While he had to "cash in some chips in the form of other positions" — giving two for one — Bruno says the trade was more than worth it.

"The importance of having someone like her is priceless," he notes. "She's physically housed in admissions and, almost daily, people go to her and say, 'Look at this, look at that, look at what happened in the system — something just fell off the screen' or 'I can't get this account to drop.' She can go in and fix problems and dissect and interpret things that we couldn't do on our own.

"Her knowledge of systems is valuable on a daily basis," Bruno adds,

"and that includes the emergency department, the business office, and outpatient registration."

Also on a daily basis, he says, Williams writes computer reports and "does things in the system we don't have the skills to do." Her expertise was crucial, Bruno adds, during a recent project that targeted accounts in the discharge-not-final-billed and outpatient-exception categories. During a two-month period, the number of unbilled accounts in those categories was reduced dramatically, representing a dollar amount of more than $5 million. **(See articles in the August 2003 issue of *Hospital Access Management*, on pp. 85 and 91.)**

An important part of her role, Williams says, is acting as a liaison between patient access and the hospital's IS operation, which still is outsourced to FCG.

"I can 'talk the talk' and know exactly what we need to do to keep things moving," she adds. "I do my own research when we have system problems and let [IS] know the details."

Before her stint with FCG, Williams notes, she was a systems analyst for Presbyterian, handling patient accounting, order entry and charge entry issues, working with patient registration pathways, and building screens.

While FCG is contracted to do those functions for the entire hospital, Bruno says, "having our own inside person" means problems are handled efficiently and quickly.

"In the old days, we would have to put in a service request [to the IS department], go in a queue, and it might take weeks or months before we got a response," he adds.

'It's opened my eyes'

Working for the patient access department, rather than coming in as a representative of IS, she "looks at everything from a different perspective," Williams says. "I see how working with IS can be challenging. It's opened my eyes a lot. I can understand the frustration that a lot of users have if they don't have IS knowledge."

Now that Williams has the "user perspective," Bruno points out, "she can be even more instrumental to us in getting across to IS the problems patient access employees face, but can't describe accurately enough. It helps expedite things."

Recently, for example, that perspective came in handy in regard to an interface between the outpatient clinical system that physicians use and the patient registration system, Williams says.

"Instead of [patient access] duplicating registrations in SMS, [physicians] interface that information with us," she explains. "We had a lot of different mapping tables and a piece in between to make it work, and it didn't."

"I could identify where the pieces were broken and, after working with patient access, identify other places that were broken," Williams adds. "I was able to compile a list of 31 interfaces, give it to IS and say, 'We need these fixed.' They weren't even aware of the different problems we were having."

Williams actually started her career at Presbyterian as an admissions clerk, and worked in the

(Continued on page 136)

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Top 10 Ways to Survive and Be Successful in Patient Access Management

By **Anthony M. Bruno**, MPA, MEd
Director of Patient Access and Business Operations
University of Pennsylvania Medical Center
Philadelphia

10. Learn your boss' agenda and values. Always keep your boss informed about departmental issues and situations and never place your boss in an embarrassing situation. Don't work for someone who does not have values similar to yours. It just doesn't make for a productive work environment.
9. Don't be afraid to change jobs when necessary. Changing hospitals and jobs will keep your creative skill sets and instincts sharp. Each hospital and access department will present you with new challenges.
8. Volunteer, especially for difficult assignments. Gain a reputation as someone who can be counted upon to "get things done," but expect to be asked to take on assignments that will stretch your skill sets.
7. Expect to be criticized, but never criticize others. Just don't take criticism personally. Always be cooperative and set an example as a collaborator.
6. Get organized. Make lists, keep track of your projects and commitments to your customers, and place a high value on hiring staff with great organizational skills.
5. Recognize and reward employees, especially those who are helpful to your customers and display a driven-by-team-success attitude.
4. Hire staff members who are more talented and smarter than you are. It's a cliché, but it has been proven to be good advice. It's just more fun to be surrounded by talented people at every level of your organization who have creative skills and are innovators. Talented people will keep you challenged to continuously improve your department.
3. Be continuously customer-focused. Management is all about knowing who your customers are and how to impress them with your customer service. Make decisions that support the needs of your customers.
2. Know and value the **4 Rs**:
   - Recruit and select the **right person**. Hire for attitude, train for skill. Look for someone who values customer service.
   - Place staff in the **right jobs**. Ensure that staff are placed in the right jobs by matching staff skills sets to the job requirements.
   - Provide staff the **right training**. Support continuous staff education and training. Each employee must know his or her role and how to complete responsibilities for your team.
   - Perform in the **right environment**. Position staff to perform job tasks in the right environment. Ensure that staff have the right work tools and that they know how to use them.
1. **Balance your time between your work and your family. Get to work very early in the morning and try to get home each evening to have dinner with your family.**

(Editor's note: Anthony Bruno has been a patient access administrator since 1984, working as a department head at several New York, New Jersey, and Pennsylvania health systems, including Albert Einstein Medical Center in Philadelphia and Mount Sinai Medical Center in New York City. He has been a presenter at three National Association for Healthcare Access Management conferences and is president of the Philadelphia Area Healthcare Access Management organization, among other achievements and awards in the access field. Bruno also serves as a member of Hospital Access Management*'s Editorial Advisory Board.)*

ED and as a unit secretary, before starting her IS experience as a data entry clerk and then moving on to database administrator and beyond. Those early positions later helped her understand when users called with an IS problem, she says.

"Now in patient access, I can see how everyone has to work as a team and pull everything together," Williams adds.

The only way to go

Bruno notes that he had been lobbying to make Williams a part of the access department for a year before the move took place, but had not been able to convince hospital administrators at that time.

Fortunately, he says, when she was poised to leave the organization for another job, "cooler heads prevailed. My boss says now, 'Boy, am I glad I listened to you.'

"Having your own systems analyst is the only way [for access departments] to go," Bruno contends. "If I had to say one thing [to argue the case], it would be that it's a matter of getting problems solved on a timely basis, and making everyone she works with work smarter."

Other managers, he notes, have acquired system skills they would not have learned without having Williams to teach them.

In response to the question that hospital administrators will likely raise — "We've got IS; why does patient access need someone?" — Bruno underscores the importance of the different perspective that is provided.

"When she was just serving us," he adds, "Marilyn had a different set of hats on. Now that she's with us, she's also part of team building, part of the management team. It's just a better approach toward helping the front end do the job you want it to do."

(Editor's note: Look for the next step in the creation of the University of Pennsylvania Medical Center-Presbyterian's access department — adding responsibility for medical records — in a future issue of Hospital Access Management*. Anthony Bruno can be reached at anthony.bruno@uphs.upenn.edu. Marilyn Williams can be reached at marilyn.williams@uphs.upenn.edu.)* ■

Financial woes force 'heartbreaking' choices

Rationing uncompensated solution to budget crisis

Frontline access management staff at the University of Texas Medical Branch (UTMB) in Galveston face excruciating tasks on a daily basis.

How do you tell a chronically ill single mother with outstanding debts to the hospital that she must work out a plan to repay what she owes before a new appointment can be made?

Or, in another case, how do you tell a man with no insurance, but too much income to qualify for public assistance, that he must come up with a copay he feels he cannot afford in order to be seen?

This wasn't always the case.

For more than a century, the 110-year-old public hospital was the place that provided medical to anyone, regardless of their ability to pay, no questions asked.

According to UTMB president **John Stobo**, MD, patients came to the hospital from 180 of the entire state's 254 counties, with even more people making 1,000-mile trips to get prescriptions filled at the hospital's pharmacy, which handed out six-month supplies to indigent patients free of charge.

All that began to change in 1998.

Cutbacks in federal and state support for the public hospital hit at the same time it was seeing its amount of unreimbursed care steadily rise and the cost of medicines and supplies double and triple.

By the end of the year, the hospital was reporting $80 million in debt and faced with depleting its reserves just to keep the lights on.

At first, Stobo and other hospital leaders tried traditional forms of cost containment. They reduced the number of beds and cut almost 600 staff. They cut programs they felt they could do without and had not been performing well — the home health agency, hyperbaric oxygen treatments, and Life Flight went by the wayside.

But at the end of the day, Stobo says the cuts weren't nearly enough to close the gap.

"We realized that we had to look at the amount of uncompensated care that we provided," he says. "I resisted doing that for more than a year. But, ultimately, we had to look at triaging — or rationing — care."

A rational, consistent approach

Stobo convened a committee of hospital leaders — representatives from the clinics, different medical specialties, hospital admissions personnel, and

management — to develop a system that would ration the hospital's resources in a clear and consistent way.

The committee came up with a codified program, known as the Demand and Access Management Program (DAMP), which established rules for limiting uncompensated care.

They began by asking all new patients — not just those covered by insurance — to pay an $80 copay unless they could meet the hospital's criteria for being indigent (less than $2,800 per month for a family of four or 185% of the federal poverty level). Indigent patients qualify for a discounted copay of around $30.

Children never are turned down, but adults who cannot make the copay are evaluated by a physician to determine whether their condition presents an immediate threat to their health. If not, they are turned away.

Screening provides important info

But the admissions personnel who perform the financial screenings also work with people to determine whether they may be eligible for federal or state programs that would help cover the cost of care, or whether they might be able to receive covered care in another setting, says **Barbara Thompson**, MD, chair of the department of family medicine and medical director of the hospital's clinics.

For example, when they started looking at where "unsponsored" patients were coming from, they discovered that 26% of patients presenting for care without an ability to pay for it were from Harris County, TX, the county that contains the city of Houston, as well as the University of Texas Health Sciences Center, a Veterans Affairs hospital, several other hospitals, and, most importantly, the Harris County Hospital District, another large publicly supported hospital.

"We discovered that some patients come here who really have another source for health care," Thompson recalls. "We did have a number of patients coming to us from Harris County that Harris County wanted to come to them, they receive funding to care for indigent patients in their county, but, for whatever reason, they found it easier to get into our system."

A key focus of the screening process is to help determine what funding sources are available to help low-income patients of which the patients might not be aware.

"Of course, some patients don't have another source, and still don't qualify for assistance, and it is those people we need most to help. We need to make sure that we are taking care of the patients that are most in need, especially since we have decreased resources now," Thompson says.

Patients who already have an established relationship with the hospital do not go through the financial screening process, but patients with outstanding obligations to the facility for a previous episode of care do have a bad-debt "flag" attached to their records that alerts personnel if they return to the facility.

"If they can make any kind of arrangement at all, sometimes just $5 per month, then we go ahead and make the appointment," she notes. "But unfortunately, they do get that notification that we need to have something in place in order for us to see them again."

The hospital continued to make changes that affected all patients — moving to a specific drug formulary and ending some expensive and experimental treatments.

The pharmacy also stopped providing a six-month supply of medications to patients who could not pay — now, they only get 14 days' worth. The pharmacy has gone from losing $12 million per year to just $1 million.

EDs bear the brunt

Of course, the limits on access placed on nonurgent care means more patients are likely to end up in UTMB's and other hospitals' emergency departments (ED)— often after their condition has become more severe, Thompson says.

"I think that is the real possibility," she continues. "What is going to result, all over the country, is more people going to emergency rooms and clogging emergency rooms, which impacts health care for everyone."

The financial crisis faced by UTMB is not unique, she notes. All over the country, public hospitals, particularly teaching hospitals, are seeing their subsidies for indigent care cut as states face budget shortfalls. At the same time, record numbers of people are without health insurance — 2.4 million more people lost coverage last year — and are turning to public hospitals for care.

For years, these hospitals have been the safety net for problems that society would like to ignore — the working poor who become ill and can't afford treatment. Now those hospitals, unable to absorb any more debt, are pushing the problems back.

The problem is particularly acute in Texas, currently facing a multibillion-dollar budget shortfall, with almost a quarter of its population uninsured.

As the health care system struggles under the weight of the mounting financial costs of providing care, the care provided to even wealthier, insured patients likely is to be affected, she notes.

With more patients crowding the UTMB ED last year, the hospital was forced, for the first time in its 110-year history, to go on ambulance diversion for a period.

"One of my patients who has insurance and has lived here on the island for a long time, had to go to the hospital during this time, and they didn't bring her to our ED. They took her somewhere on the mainland," Thompson says. "She couldn't believe it and neither could I. But if things like that happen more and more, maybe people will start waking up."

Decisions based on values

What UTMB is doing with DAMP is acknowledging that rationing in health care inevitably occurs and attempting to establish policies that ration care consistently and openly across the board so that the procedures and methods can be scrutinized, says **Ronald A. Carson**, PhD, director of UTMB's Institute for Medical Humanities, a member of the institute's ethics consultation service.

"We ration all the time in this country, but most doctors feel better about it because they take care of the patient in front of them," he explains. "They have not been aware, and the public has not been aware — certainly the legislators don't seem to be aware — that there is a queue. That is one way we ration care; we take care of the people who can get into the system and then there are people who cannot get into the system because we run out of medicine or we run out of money or we run out of time."

The hospital's mission since its founding has been to serve the poor, and the hospital is committed to continuing to do so, but it has to find a way to serve those most in need, while staying solvent enough to remain in existence, he says.

"This has involved a change in culture," Carson admits. "Before DAMP, we took care of everyone who showed up, and we were taking it on the chin. It was unsustainable. Now, what we have to do is say, 'Yes, we are rationing care.' Admit it up front; use the 'R' word, and talk about it."

Carson served on the initial committee that developed DAMP and continues to work with the medical leadership to evaluate how it is working and its impact on the facility and the people it serves.

"My emphasis is really more on patient care. Who is getting access? What kind of job we are doing taking care of people who don't have anywhere else to go?" Carson says.

Efforts at enrolling patients eligible for Medicaid, Medicare, and other programs, and efforts to redirect people to their local systems that can provide subsidized care, are two ways that UTMB seeks to reduce its burden and preserve its scarce resources for people who really need it, he says. "We are fully committed to remaining a safety net hospital, but what we are trying to do is ration access, in a morally responsible way, to our system."

Even hospitals that don't consciously ration the care they provide are rationing care in a thousand different ways each day, he notes. Each time a physician must make a choice about which patient gets the one remaining ICU bed, or which patient should get an expensive test or medication the facility is trying to limit, rationing occurs.

"If you leave the policy decisions — or the decisions that are tantamount to policy decisions — to individuals at the bedside or consulting room, you can't be doing it fairly, because you just don't see the big picture," Carson says. "What ends up happening, even with the best intentions in the world, is that judgments that have nothing to do with medical indications get made — people get triaged and care gets managed on the basis of all kinds of things, social merit, and so on. I am not blaming anyone. It happens inevitably when you are thrust into that situation as a caregiver."

Sleepless nights

Although the staff at UTMB are getting more accustomed to working within the DAMP system, it still produces frustration and heartache, says Thompson.

Looking at the big picture may be the best way to provide the best care possible to the most number of people, but the individuals who do not receive needed care are real, and they stay with you.

"As a physician or a nurse and health care provider, you swear an oath that the financial piece will not be a factor. This is heartbreaking. I cannot tell you the number of nights I have

woken up worrying about it," she says. "And people say, 'Well, just be sure the decisions are in the hands of physicians and nurses and people actually providing care and that they are not in the hands of the financial folks.' But I look at some of my team members and colleagues [who are the financial folks], and they feel the same way."

(Editor's note: John Stobo, Barbara Thompson, and Ronald A. Carson can be reached at University of Texas Medical Branch, 301 University Blvd., Galveston, TX 77555.)

Suggested reading

• Wysocki B. At one hospital, a stark solution for allocating care. *The Wall Street Journal.* Sept. 23, 2003. ■

Advance copay reminder boosts hospital collections

Patients get 'lead time to plan'

South Shore Hospital in Weymouth, MA, is collecting thousands of dollars more each month, thanks to a new initiative aimed at making sure patients are aware — in advance — of their copays.

Since May 2003, a financial counselor has been calling maternity patients — more recently all elective inpatients are being called — and informing them of the copay required by their insurance, says **Betty Wisgirda**, CHAM, director of patient access. Many patients don't check the details of their insurance; they just know they have it, she notes.

"We have a large maternity program, and these patients are focusing on the baby-to-be, not their insurance," Wisgirda adds. "We've taken it upon ourselves to educate them. I hate to see these young people go home and realize they have a $1,000 copay. We've actually had some of the maternity patients' [bills] go to bad debt."

"It was more that they didn't understand and weren't prepared," she notes, "and when the baby is there, there are so many more calls for those dollars."

Some HMOs, which are pervasive in Massachusetts, also charge a copay for the baby, which doubles the patient's financial responsibility, Wisgirda says.

Starting at about the sixth month of pregnancy, she explains, "we call them, say, 'We've checked your benefits and eligibility, and this is what you owe.' We want to give them enough lead time to plan, to think about how to budget for this if they need to."

Some don't need to, she adds, and just say they'll pay the copay at discharge. In other cases, Wisgirda says, the hospital arranges a payment plan. The patient also is given the option of paying by credit card.

Although people initially were surprised that the hospital was calling to ask them for money, she says, "they've been very responsive when we explain the size of the copay and say we want to make sure they're aware of it. We're giving them a chance to do it in advance of the procedure."

The financial counselor makes the call in advance of every elective admission — not just OB cases — and on every insurance, Wisgirda notes.

Although she didn't have firm totals at the end of October 2003, Wisgirda estimates the hospital is collecting about $25,000 a month as a result of this initiative. "Before, we weren't collecting anything."

By eliminating, in many cases, the need to bill patients after the fact and wait 30, 60, or 90 days for payment, she notes, the hospital is receiving its payment earlier, when it is more valuable.

Tracking system aids ED collection

Thanks in large part to a tracking system whereby patients' names are color-coded depending on their treatment status, the successful collection effort also is taking place in the emergency department (ED), Wisgirda says.

"We have a tracing system in the ED, so that when a patient has been seen by a physician, a physician's assistant, or a nurse practitioner, the unit coordinator changes the color on the patient's name in the system," she explains. "The financial counselor knows the person has been seen and can go in and collect the copay."

The tracking system, a product of the Wakefield, MA-based vendor PicisMSM, allows different views of patient information for different employees, Wisgirda notes. "The financial counselor has a view that brings over the insurance information."

The counselor knows that in worker's compensation cases or if the injury is the result of an accident,

she doesn't have to speak with the patient, Wisgirda adds. With insured patients, she says, the financial counselor can see via the tracking system either the amount of the patient's copay, or how to check the person's eligibility to obtain that figure. "She knows to go in [to the treatment room] and what [payment] to ask for."

Before the clinician's screening of the patient, Wisgirda notes, registrars do an initial registration, which may be completed at various points in the service continuum, and get the person's name, date of birth, and other demographic information so that an account number and medical record number can be entered into the system. "They just can't talk about payment," she adds.

Effort paying off

As a result of the ED collection effort, which began about the same time as the inpatient initiative, the hospital now is collecting an estimated $15,000 per month, Wisgirda says. As with the inpatient copays, nothing at all was being collected previously.

Buy-in from nurses has been crucial to the success of South Shore's ED collection program, she notes, and the tracking system is particularly important, because of the hospital's widespread emergency operation.

"There is a pediatric ED, the main ED has three sections, and there's also an observation unit, so we have a lot of geography," Wisgirda notes.

The color-coding capability allows staff to communicate quickly and easily regarding patient status, she notes. "We also use the [tracking system] for a lot of other things. If [the system shows that] a patient is going to be admitted, for example, then you see that person first."

[Editor's note: Betty Wisgirda can be reached at (781) 340-8222 or by e-mail at Elizabeth_Wisgirda@sshosp.org.] ■

Cooperation, competition equal quality improvement

Access, accounting partnership is key

A relationship of cooperation and mutual respect between access and the billing department is at the heart of a successful quality initiative at Children's Health Care of Atlanta, says **Millie Brown**, director of patient access.

"Typically, you have the business office looking at access and saying, 'These are all the things you didn't do right,' and access asking, 'Why can't they see what we do right?'" she notes.

When she left her position as business office manager to become access director, Brown says, she provided a wake-up call to both sides of that debate. She reminded the business office staff that 80% of the hospital's bills are paid the first time out. "I said, 'You guys are looking at those that were denied — everything that was paid has no reason to come to you.'"

With patient access staff, Brown adds, she took the focus off blame by saying, "Of [the bills] that are wrong, here are those you can do something about. I don't want to say, 'You got X number of denials.' I want to say, 'When putting the Blue Cross Blue Shield numbers in, be careful because . . .'"

"We're never going to be sensitive over anyone making an error," she says. "That's the culture we've been able to create. I believe that people want to be part of a winning team, and if you can give them the energy and the tools, most people want to do a good job."

Monthly meetings attended by Brown, the departmental trainer, and an access manager or two — along with a similar team from patient accounting — foster the atmosphere of cooperation, she notes. "Sometimes someone from utilization review joins us if we're discussing a pre-cert issue."

At these meetings, Brown says, "We regularly look at the denials, which are tracked by the business office, and sort them out to determine which are based on information generated by access. Then we look at those to spot for trends, so we can implement training around those trends."

The quality initiative Brown spearheaded between January and December 2002 reduced the health system's annual denials by approximately $20 million. **(See cover article in the July 2003 issue of *Hospital Access Management*.)**

Competition motivates staff

Key to that success, she explained, was a competition among registrars for gold, silver, and bronze medals, based on registration accuracy. To receive a gold medal, access employees had to have an average accuracy score of 90% or more on the components of the registration that, if not

correct, would lead to a denial.

For the year 2002, six registrars got a gold medal. For 2003, 81 of the 100 access employees have earned that honor. "That says something about competition," Brown points out. "They don't want to look bad in front of their peers."

The person with the top quality score and the person with the highest point-of-service cash collection total were given DVD players in recognition of their achievements, she says.

Three other awards, based on staff votes, were made to the employees who best represented the spirit of teamwork, "the people who pitch in and help," Brown says. "I ask [access employees], 'Who's the person you feel always helps you, the one who is the best representative of what a good worker is?'"

Those recipients — one from each of the health system's two hospitals and one from a separate business office location — got a day off work and a day at a local spa, she says. Brown points out that each won by a large margin, indicating that it's very apparent to their colleagues who these team players are.

Recently given responsibility for billing office quality as well, Brown was in the process of designing a plan to foster improvement in that area.

One thing she knows for sure is that productivity measures now will be based on the number of claims that resulted in payment, Brown says, not the number of claims worked.

"I say not all activity is productivity," she adds. "I don't want to know how many claims you went through on your queue, but how many you went through that resulted in payment."

For each biller, Brown will be looking at how many of the claims they handled went through after the first time they followed up, how many after the second time, and how many took three or more times, she notes.

"We'll sort those out and go to the specific problem and the specific individual," Brown explains. "Their [quality] scores will relate directly to the score on their evaluations. So if they get an excellent — a rating of 4 — based on their scores, they get a 4 on the evaluation."

As with the access personnel, she "will put out the averages and let them compete with each other. The best $7 I ever spent was on those gold, silver, and bronze medals," Brown adds. ■

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ACCESS FEEDBACK

What if care's given, consent not obtained?

Some refuse to sign, fearing obligation

The dialogue among *Hospital Access Management* readers continues as access managers work to fine-tune processes and enhance cash collection in the emergency department (ED).

Natalie Woodburn, RN, patient registration supervisor in the ED at St. Mary's Hospital in Leonardtown, MD, has a question regarding the obtaining of "consent for treatment" in cases in which treatment has already been provided.

At her facility, she explains, an employee known as a guest relations associate greets patients as they enter the lobby of the ED and performs a "quick registration" — getting name, date of birth and Social Security number — in order to match the person with an existing hospital account if possible.

From there, Woodburn adds, patients go to a triage nurse, who directs them to "fast-track" care or to the main ED operation, depending on their condition. After the person is in a treatment room, Woodburn says, the registrar may go in before or after care has been provided, depending on how quickly the physician or other caregiver comes in.

"We don't stop the physician or nurse from going in, but if they don't go in right away, registrars do go in and begin to register," she says. Registrars typically complete the registration, get the consent, and place a wristband containing name and date of birth on patients before they have received any service other than screening.

There have been times, however, that complete care was rendered before the registration was completed, Woodburn notes, and before insurance information was provided or consent for treatment obtained.

In some cases, she says, people who have brought in minors for treatment have refused to sign the consent form after care has been provided because they are afraid of being responsible

for the bill.

"Where do you stand if you've provided treatment without consent and the person refuses the obligation to pay?" she asks. "I understand there is something called implied consent, but that doesn't stand up in a court of law."

Nurse cooperation sought

Woodburn also welcomes suggestions on how to get nurses to buy in to the effort to get payment — or at least billing information — from ED patients before they leave.

"We don't have a discharge station, but it is part of our policy and procedure for clinical staff to send patients back to the registrar if the registration hasn't been completed," she says. "[Nurses] are not good about complying with that. They're more concerned with getting the patient in and getting them discharged. They want to have a one-hour turnaround."

Because in most cases hospital nurses have not had to be aware of "what happens if we don't get paid," Woodburn notes, helping to facilitate the payment process "is not on the top of their list."

"It is on the top of our list," she adds, "because we get feedback from the business office."

Although she and others are working on getting hospital administration to put pressure on clinical staff in this regard, Woodburn says, the comparatively low tab for ED visits makes getting paid for them a low priority.

Laura Fawcett, a Detroit-based manager for the consulting firm Cap Gemini Ernst & Young, says overall organizational buy-in is the key to a successful collections process. "If the top is supportive, everybody else seems to fall in line," she notes.

Fawcett suggests that Woodburn do some mathematical calculations to demonstrate to administrators the amount of revenue the hospital is missing by failing to focus on both upfront collections and stringent discharge procedures the ensure proper registration.

Although administration's view might be that collecting after the fact is acceptable, she notes that her firm estimates it costs about $25 per account to send out a bill. With copay amounts often in the same range, Fawcett adds, "if you don't collect up front, that's really all of your [profit] margin."

Among her clients, Fawcett says, "we are seeing [hospitals] give incentives" to boost collection efforts. "Based on historical collection rates, they set monthly targets that are both staff-specific and for the overall department."

Employees who meet or exceed these goals receive awards, such as gift certificates, she adds.

"The only other thing that helps — and it's not an easy fix — is [addressing] how the department is laid out," Fawcett points out. "When the patient flow is set up so that there is a checkout area, it really ensures that [registrars] get the patients before they walk out the door."

Without the buy-in of top management, of course, that change isn't going to happen, she notes.

[Editor's note: If you have feedback on this issue or other concerns of interest to access professionals, please contact Lila Moore at (520) 299-8730 or by e-mail at lilamoore@mindspring.com.] ■

CDC issues draft report on SARS preparedness

'Access controls' addressed

As hospitals put procedures in place for the possible reemergence of severe acute respiratory syndrome (SARS) during the approaching respiratory disease season, the Atlanta-based Centers for Disease Control and Prevention (CDC) has issued a draft report designed to assist in those efforts.

A number of recommendations regarding the role access departments will play in SARS preparedness are in the report, including steps for restricting access to health care facilities and for implementing effective surveillance and screening.

An informal survey by *Hospital Access Management* showed access professionals are gearing up for a potential SARS outbreak, with efforts typically centered in the emergency department (ED).

Patients at the University Hospital of Arkansas in Little Rock, for example, are triaged by ED clinicians before her employees ever see them, says **Holly Hiryak**, RN, CHAM, director of hospital admissions. "If patients are suspect for SARS, [ED clinicians] relay the registration information to us."

His staff consult a book of signs and symptoms when triaging suspected SARS patients, and ask a few key questions if those signs and symptoms are present, explains ED director **Glenn Raup**.

"The signs/symptoms are those that appear flulike — cough, fever, chills, etc. — over the past two to 10 days," Raup says. "The questions have to do with travel outside the country — and where — or travel through an airport within the past month. This is done at triage by the technician while collecting the initial data."

If the findings are positive, he adds, the patient stays at the triage area and the technician notifies the triage nurse or the charge nurse.

"From there, the nurse will confirm the answers to the questions, review the vital signs, and if the level of suspicion is still high, notify the ED attending physician to come to triage and see the patient."

If the ED attending physician also suspects SARS, Raup says, "the patient is given a mask and taken directly to one of our three negative-pressure rooms. The rest of the staff is notified, signs for general isolation precautions are placed on the door, and the department of health is notified."

Plan offers framework

The draft plan, which is available at www.cdc.gov, suggests the following activities under the heading "Hospital Access Controls." According to the plan, these steps should be taken when SARS is present in the community surrounding a health care facility:

- Establish criteria and protocols for limiting hospital admissions, transfers, and discharges, in accordance with local/state recommendations and regulations, in the event that nosocomial SARS-CoV transmission occurs in the health care facility.
- Establish criteria and protocols for closing the facility to new admissions and transfers, if this becomes necessary.
- Establish criteria and protocols for limiting hospital visitors.
- Determine when and how to involve security services to enforce access limitations. Consider meeting with local law enforcement officials in advance to determine what assistance they might be able to provide. ■

NEWS BRIEFS

Insured patient visits behind ED increase

Insured patients, not the uninsured, accounted for most of a 16% increase in emergency department visits between 1996 and 2001, according to a recent analysis by the Center for Studying Health System Change.

The study found that emergency department (ED) visits increased 24% for privately insured patients, 10% for Medicare beneficiaries, and 10% for self-pay or no-charge (typically uninsured) patients during the period. It also found a 37% decrease in physician office visits by uninsured patients during the period, an indication that medical resources other than EDs are dwindling for uninsured Americans.

The report, based on data from the Centers for Disease Control and Prevention, is available at www.hschange.org. ▼

AHA form available to report problems

A form that hospitals and other health care organizations can use to report problems they encounter sending or receiving electronic transactions using the Health Insurance Portability and Accountability Act (HIPAA) transaction standards is available on the American Hospital Association (AHA) web site.

AHA will use the information to identify quickly specific problem areas that may warrant correction or intervention by the Centers for Medicare & Medicaid Services (CMS), according to a spokesman for the association.

COMING IN FUTURE MONTHS

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The form can be accessed at www.aha.org by clicking on "HIPAA." It includes a link to the CMS web site, where organizations can file an official complaint. ▼

Part A deductible rise set for 2004, HHS says

The Part A deductible, paid by beneficiaries in the fee-for-service Medicare program for certain services, including inpatient hospital care, will increase by $36 to $876 in 2004, the Department of Health and Human Services has announced.

For extended hospital stays, the per-day payment for days 61-90 will increase by $9 to $219, while the per day payment for hospital stays beyond the 90th day in a benefit period will increase by $18 to $438.

The monthly premium paid by beneficiaries enrolled in the optional Medicare Part B program, which covers services including outpatient hospital care, will increase by $7.90 to $66.60. More information is available at www.hhs.gov. ▼

Pay raise predicted for new registrars

The median pay for newly hired registration/admission clerks will grow 7.4% in 2004, compared to 2003, says a forecast by OfficeTeam, a temporary staffing and job placement company.

Hospitals and other health care providers are likely to provide healthy pay increases for starting administrative staffers in 2004, compared to the unchanged or even declining salaries paid to administrative workers in other economic sectors, the report says.

The general pay range for registration/admission clerks will be $20,250 to $27,500, not counting regional pay differentials, according to OfficeTeam. The company also predicted that newly hired medical office administrators will get 7.9% more than their counterparts did in 2003, with pay typically ranging between $33,500 and $45,000 annually.

"Ongoing shifts in regulations impacting the health care field have increased the need for skilled workers who can readily adapt to changing job requirements," the company said. More information is available at www. officeteam.com. ■

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2003 Index

When looking for information on a specific topic, back issues of Hospital Access Management *newsletter, published by Thomson American Health Consultants, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com.*